WHO-EM/CAH/185/E

Report on the

Regional IMCI coordinators' meeting

Amman, Jordan

2–6 September 2007

World Health Organization

Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

The World Health Organization (WHO) Regional Office for the Eastern Mediterranean (EMRO) held a regional IMCI coordinators' meeting in Amman, Jordan, from 2 to 6 September 2007.

The main purpose of the meeting was to review progress of implementation of the Integrated Management of Child Health (IMCI) strategy since it was introduced in the Eastern Mediterranean Region in 1996 and set the way forward. More specifically, the objectives of the meeting were to:

- discuss progress of scaling up the IMCI strategy to reach the targets of the Millennium Development Goal of reducing child mortality (MDG 4);
- discuss mechanisms for scaling up IMCI to increase IMCI coverage;
- update countries on new areas of child health within the IMCI context, particularly neonatal health; and
- review progress of the IMCI community component.

A total of 76 participants attended the meeting, including 53 representatives from ministries of health and universities of 16 countries in the Region, staff from Aga Khan Health Services/Pakistan, Medicus Mundi/Andalucia, UNICEF (Regional Office for the Middle East and North Africa and three country offices), United Nations Relief and Works Agency/Jordan and WHO (headquarters, Regional Office for the Eastern Mediterranean and five country offices). The programme and the list of participants are included as Annexes 1 and 2, respectively.

2. IMCI IMPLEMENTATION STATUS

2.1 10 years of IMCI implementation in the Eastern Mediterranean Region

An estimated 1.3 million under-five children keep dying in the Eastern Mediterranean Region every year, about 40% of them being newborns. Just two countries in the Region, namely Pakistan and Afghanistan, are responsible for more than half of these deaths, while overall 97% of all deaths occur in eight countries. Most of these deaths are preventable through existing cost-effective interventions. However, the coverage of these interventions is low. Leading causes of under-five mortality in the Region include acute respiratory infections, especially pneumonia (19% of all under-five deaths), diarrhoeal diseases (18%) and perinatal-related causes

of death, the most common of which are severe infections (28% of neonatal deaths), prematurity (22%), birth asphyxia (20%) and neonatal tetanus (12%) (2005).

Primary health care plays a crucial role in the delivery of preventive and curative care for the child population in the Region, yet it lacks the required support in a number of countries to achieve its aims. The Integrated Management of Child Health (IMCI) strategy was introduced in the Region late in 1996. Since then, about 60% of health facilities have been implementing it in 14 countries. Since its introduction, the strategy has broadened its scope, addressing policy (Child Health Policy Initiative), strengthening its feeding component (child feeding counselling training), adding child development (care for psychosocial development) and covering the child from birth (neonatal health). With its conceptual framework, expanded scope and three-component emphasis on human resource development, strengthening of health systems and improvement of family child care practices, the strategy has increasingly been defining its role in the Region as the "Primary Child Health Care" strategy, as stated also by Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, in his opening remarks[1]. To date, 17 countries in the Region have introduced the strategy. Different patterns of implementation can be identified among these countries.

o *Rapid progress:*

- *despite substantial workload*. An example includes the Islamic Republic of Iran, which adopted a standardized decentralized approach, with Ministry of Health and Medical Education and partners' commitment and 98% of its targeted health facilities implementing IMCI by the end of 2006. Another example includes Egypt, which built a strong national capacity for implementation and reached 77% coverage of health facilities within the same period despite a high turnover of trained staff.

- *despite difficult circumstances*. This is the case in Afghanistan where, thanks to the Ministry of Public Health commitment, WHO technical support, partner commitment and collaboration and the approach followed for implementation, health facility coverage reached more than 50% in just three years. A strong role has been played by nongovernmental organizations in delivering services in Afghanistan.

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[1] http://www.emro.who.int/cah/IMCI-About.htm#section11 accessed on 1 September 2007. The focus is currently on children under the age of five, who remain the most vulnerable age group.

- *followed by a reduced pace of implementation*. An example includes Tunisia, which started with strong commitment of the Ministry of Public Health and national team but later faced turnover of the management team at central level and the constraint of an insufficient pool of facilitators to expand rapidly. Another example is Djibouti, which initially progressed quickly with strong government commitment, WHO technical support and partners' collaboration, but was then adversely affected by a high turnover rate of health facility staff which negatively influenced health facility coverage levels.

o *Periods of progress alternating with slow pace of implementation*. An example includes Morocco, where inadequate commitment to the IMCI strategy and resources allocated to it slowed down implementation substantially in certain years, followed by increased advocacy and resources and then a reduction again, with only 25% of facilities covered in 9 years of implementation.

o *Very slow initial progress, followed by accelerated implementation*. This is the case of Pakistan, where declining government commitment, lack of a national plan and competing priorities among international partners paralysed implementation for about five years at about 1% health facility coverage. Renewed interest, with endorsement by senior paediatricians and professional associations, improved partner coordination and WHO country level support, all led to an accelerated phase of implementation which increased coverage up to 4% in just the following two years.

Weak health information systems, inconsistent data or lack of reports have been a challenge to monitor IMCI implementation in some countries.

IMCI implementation has been the responsibility of the ministry of health in all countries, with different levels of partner involvement. IMCI implementation has taken different 'shapes' and priority approaches in different countries compared with the strategy promoted by EMRO, which places equal emphasis on the health system component and strongly promotes and supports IMCI pre-service education.

o *Training*. Updating health provider case management skills has been a common feature of IMCI implementation in all countries, helped by the presence of an available standardized training package and methodology. Alternative approaches to training have been adopted by a few countries, including the development of a competency-based training course for paramedical staff and shorter, intensive courses for physicians (9-day—Tunisia—and 7-day courses—Egypt, Morocco). At the same time, the conduct of follow-up visits after IMCI training has been irregular, with a few exceptions (e.g. Egypt), usually because of lack of proper planning or human and financial resources.

- *Health systems*. Only a few countries (e.g. Egypt) have provided equal attention to strengthening the second component, i.e. health system support.

- *Community component*. Very few countries have started activities under this component, mostly focusing on volunteer training (e.g. Sudan).

- *Updating the strategy and expanding the scope*. The child feeding element of IMCI has been strengthened through the introduction of the training in infant and young child feeding counselling within the IMCI strategy in two countries (Egypt, Sudan); a healthy child component has been added by four countries (Morocco, Oman, Syrian Arab Republic, Tunisia), while the IMCI guidelines have included the neonatal period in nine countries (Egypt, Islamic Republic of Iran, Iraq, Jordan, Morocco, Pakistan, Syrian Arab Republic, Tunisia and Yemen).

Over the past 10 years the Regional Office has: provided direct country support to implementation to build capacity for planning and implementation; held 19 regional events, which have included focused workshops on the Child Health Policy Initiative, IMCI community component, IMCI pre-service education and breastfeeding promotion; and engaged in developmental work to address specific needs.

The main recommendations made to countries and WHO during regional events are summarized in Annex 3. Monitoring and evaluation of IMCI implementation have covered process and intermediate outcomes through follow-up visits, reviews and health facility surveys. All countries have focused on health facilities. Changes in the child population health status are measured in countries by such studies as the Demographic and Health Survey and Multiple Indicator Cluster Survey.

A number of challenges have been met over years of implementation:

- competing priorities with inadequate allocation of human and financial resources to child health, raising the issue of reaching universal coverage within this context;

- sustaining achievements while scaling-up;

- lacking a national plan with all partners committing to it and ensuring government leadership in the whole process;

- maintaining commitment to support IMCI implementation by partners, which have been the main source of funding over these 10 years, with the challenge for countries to take over;

- addressing high turnover of trained and qualified staff at all levels;

- strengthening weak health systems;
- lack of full community involvement and ownership;
- meeting decision-makers' reluctance to invest in "quality" of care—key to impact, beyond targeting coverage.

The main conclusion is that there should be one country plan and one monitoring mechanism with agreed upon indicators to which government and partners are committed.

2.2 IMCI global implementation: opportunity and responsibilities

There is an unprecedented opportunity and an unprecedented responsibility to tackle the 10 million deaths in under-five children which are estimated to be occurring worldwide annually: we know *who* is at risk, *where* they live, *what* to do and *how* to do it. The IMCI strategy has been adopted by more than 100 countries around the world. The multi-country evaluation of IMCI has shown that IMCI is an effective strategy. It improves quality of care, can increase demand for care and utilization of services, can lead to a substantial reduction in mortality and improvement in nutritional status and is cost-effective, with costs per child correctly managed much lower than usual care. Therefore IMCI provides the knowledge and means for preventing at least two thirds of newborn and child deaths. The strategy provides essential, integrated child health care at primary health care level addressing the main issues of under-five children, whether healthy or sick. However, coverage with the essential child health interventions under the IMCI strategy is still low. In addition to the multi-country evaluation, WHO is engaged in monitoring intervention coverage and child health outcome indicators and documenting IMCI scale-up experiences in selected countries. To reach universal coverage, more investments need to be made. Government leadership and policy commitment to one national plan, with partner harmonization and coordination converging around it, are critical for scaling up and achieving the potential impact of IMCI.

3. COUNTRY APPROACHES TO SCALING UP IMCI

3.1 Moving towards universal coverage: a standardized approach – The Egypt experience

Egypt has been following a standard approach to IMCI implementation, refined over the years based on the experience gained (Box 1). Such an approach has aimed at ensuring a standard implementation across governorates and districts, enhancing the pace of implementation and actively involving all levels in planning and implementation. During the initial expansion phase, high child mortality in both Upper and Lower Egypt was a key criterion used for the selection of governorates, in addition to commitment and support of the concerned officials. Districts within the

governorate were then selected based on a set of standard criteria, jointly, during a visit to the governorate after briefing by the national team. A formal orientation, using a standard package, was then provided to a broad district audience. To inform planning, data were collected after the orientation as part of the situation analysis process over a period of 3–6 weeks using standard forms. The next step was the conduct of a 3–4 day district planning workshop, facilitated by central staff. The workshop had on average 6 districts of 2–3 governorates represented, including one governorate with previous experience. The plan aimed to cover all health facilities within one district before moving to a new district in the same governorate. A set of standard tools, mostly checklists, was used to assist in planning, from selection criteria for participants in training courses to a list of essential medicines for IMCI and guidelines to estimate medicine requirements, organization of work at health facilities and task distribution, basic supply and equipment, and monitoring. The workshops resulted in the preparation of district plans of action. Implementation of the plans was preceded by activities to build capacity for training and follow-up (pool of facilitators). While the local IMCI teams were responsible for implementation, the central team assisted in supporting and monitoring it. The last step of the approach followed in Egypt concerned information (set of standard recording and reporting forms) and documentation (e.g. review of health facility situation, training and follow-up data) to be used for advocacy purposes, planning, monitoring and evaluation. Detailed annual reports were prepared at national level and distributed with this information and its analysis. This standard approach, with well identified and shared responsibilities between the central and local teams and a set of tools, allowed a steady progress in implementation, with the number of districts covered doubling every two years (Figure 1). Despite this, reaching universal coverage in the country is challenged by limited financial resources of the Ministry of Health and Population coupled with reduced financial support from partners at this critical time, additional and competing responsibilities assigned to central staff, high turnover of IMCI-

Box 1. 8-step approach to IMCI implementation, Egypt

1. Governorate selection
2. Initial visit: district selection
3. District orientation
4. Data collection
5. District planning workshop with situation analysis
6. Governorate capacity building
7. Implementation and monitoring of the plan
8. Information and documentation

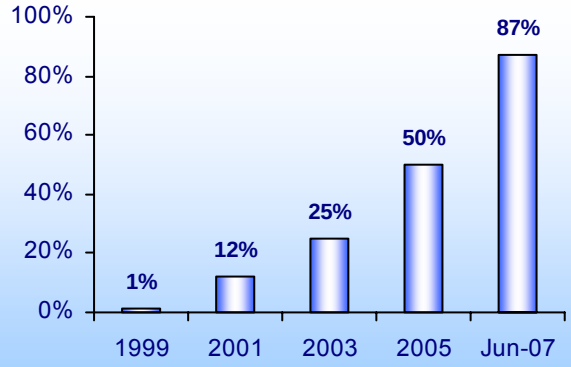

Figure 1 Progress of district implementation, Egypt, 1999–2007

trained health facility staff and facilitators, and delays in the implementation of the community component.

3.2 Political commitment and partnership – The Pakistan experience

After the initial introduction of the IMCI strategy in the country, with an evaluation followed by its endorsement for expansion in 2002, the pace of implementation slowed significantly in Pakistan. Lack of funding was not the reason in this case. Instead, IMCI became an "orphan" strategy, with lack of a national child health policy and strategy, sub-optimal coordination of partners and changes in the management structure. The initial vertical approach to implementation had consequences for provincial ownership at a time of devolution and decentralization. After several unproductive years, the situation took a positive evolution in 2005, also triggered by the slow progress towards the achievement of the Millennium Development Goal 4 (MDG 4) on reducing child mortality (see Figure 2). Partner coordination improved and support significantly increased. A national child health strategy was developed and launched at a formal forum with all key stakeholders and high-level firm government commitment at prime ministerial level. The amount of US$ 333.3 million was allocated to the newly established maternal, neonatal and child health programme. IMCI was recognized as a key strategy to achieve MDG 4 with renewed interest of the provinces. Among the new challenges were the need to develop innovative approaches to service delivery for far-flung and underserved areas, including slum areas and those not covered by the Lady Health Workers, a network of about 100 000 health workers.

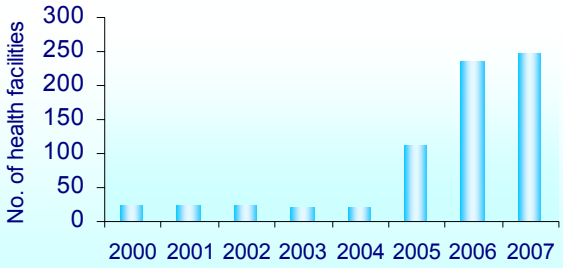

Figure 2 Cumulative health facility coverage, Pakistan, 2000–2007

Aga Khan Health Service (AKHS), Pakistan, provides a promising example of partnership between the private sector and Ministry of Health. AKHS is a non-profit and nongovernmental community-based organization. It aims at developing an effective, integrated health service delivery system, in collaboration with other AKHS partners, organizations and the government. It runs 167 health centres at different levels in Pakistan. Since its introduction in Pakistan, AKHS adopted IMCI, creating a critical mass of regional trainers and running training courses to cover 81% of its 167 centres to date. Through a Memorandum of Understanding with the Ministry of Health, AKHS contributed to train staff of government facilities and other nongovernmental organizations. AKHS pioneered implementation of IMCI in the private sector—including mountainous areas where referral is often not feasible, and institutionalized it in its system, while using and maintaining a registration system. It identified opportunities for collaboration, such as joined planning for training courses with other partners, improving referral mechanisms and further

development of the IMCI community component, especially to improve care-seeking practices.

3.3 Scaling up IMCI in difficult circumstances: the role of government and NGOs – The Afghanistan experience

Afghanistan health indicators represent a huge challenge: under-five and infant mortality are reported as 191 and 129 deaths, respectively, per 1 000 live births, with 31% of under-five deaths occurring in the neonatal period; prevalence of malnutrition in under-five children is high. To add to this burden is a complex scenario where access is difficult due to geographic and communication problems, socio-cultural factors and a difficult security situation. In this context, important policy decisions were made to support the introduction and implementation of IMCI, namely its inclusion in the basic package for health services (BPHS)—the main vehicle for provision of health services in the country—and the inclusion of all the required medicines in the national list of essential medicines. IMCI-related messages were included in the training package for community health workers, with over 17 000 workers (52% female) trained to date. A child health task force was established by the Ministry of Public Health to coordinate child health related activities, including IMCI, among all partners. This was crucial in a situation where 80% of health facility services are provided by nongovernmental organizations, which are also responsible to identify their staff training requirements and monitoring and supervision. Through this coordination, the decentralization of training—by the establishment of three zonal centres—and recruitment of IMCI provincial focal points with a quarterly reporting system set up, there has been steady and rapid implementation of IMCI, to cover about two thirds of facilities to date, in just four years. The process also started to introduce IMCI into pre-service training.

3.4 Progress in scaling up IMCI: facilitating and hindering factors

During the meeting, a review in small groups of progress of countries in implementing IMCI highlighted the large variation existing among countries in expanding coverage. A number of factors were described as facilitating implementation when present and slowing it down when absent.

- *Experience.* Previous, successful experience with public child health programmes (e.g. control of diarrhoeal diseases and acute respiratory infections) was cited by most country teams as very helpful for IMCI implementation.

- *Commitment*. It was recognized that although policy-makers have often expressed commitment to child health as a priority area, this commitment has not translated into allocation of human and financial resources and has succumbed to other 'priorities', often donor-led. The difficulty was also

acknowledged in persuading decision-makers to invest in quality, a key requirement for effectiveness, as a priority approach.

- *Management*. Only in a few countries is the IMCI management structure institutionalized, i.e. reflected in the Ministry of Health organigram (e.g. Egypt, Sudan, Yemen). Only a few countries have developed long-term plans to reach universal coverage with IMCI (e.g. Egypt, Islamic Republic of Iran). There is often a lack of effective coordination mechanisms linking other child health programmes to IMCI. When decentralization of IMCI implementation is well planned, building capacity by creating an adequate pool of trainers and by sub-national training sites helps move forward implementation at a faster pace. When applied, a standardized approach to implementation has facilitated the planning and management of activities at different levels.

- *Human resource development and health systems*. While IMCI training continues to represent the backbone of IMCI implementation, the large majority of country teams highlighted weakness in conducting regular follow-up visits after IMCI training, which is a key step in reinforcing health provider skills and strengthening health system support. This was often ascribed to lack of planning and available resources, whether financial or human. High turnover of trained staff also poses a major challenge. Several countries have succeeded in including IMCI in health care packages. Most of the attention of the health system component in countries has successfully been placed on including the medicines required for IMCI in the national essential list of medicines, with often a policy of free dispensing to young children. At the same time, regular availability of medicine remains a common issue adversely affecting quality of child care.

- *Community component*. A few initiatives, mostly focusing on the use of community health workers or volunteers, have been implemented in a few settings, often lacking formal evaluation to expand with an evidence-based structured approach.

- *Advocacy and partnership*. Close collaboration between the ministry of health and university staff since the introduction of IMCI in countries represents a strong facilitating factor in IMCI implementation. Good advocacy initiatives have led to improved support for IMCI, although it was agreed that this is an area where much more needs to be done. The tendency of partners to shift support to new areas requires more incisive advocacy strategies to maintain or bring child health back on the priority public health agenda.

- *Funding*. Major constraints reported by country teams are the substantial reliance on and decrease over time in external funding for IMCI implementation.

- *Conflicts*. Conflicts and lack of security continue to represent major factors hindering progress in the affected countries.

4. BEYOND REACHING UNIVERSAL COVERAGE: IMCI SUSTAINABILITY

4.1 IMCI pre-service education: regional overview and Egypt and Sudan experiences

4.1.1 Regional overview

A key objective of IMCI pre-service education is to produce, in a sustainable way, competent cadres of health providers, capable of delivering quality primary health care services within the existing resources and functionality of the health system in a country. While in-service training remains critical for periodically upgrading the capacity of human resources already in the system, pre-service education potentially offers a longer term, sustainable prospect. Among its benefits are the decrease in the burden of in-service training placed on the ministry of health and increase of IMCI coverage also in sectors other than public health, as graduates represent all future health professionals. The IMCI pre-service education approach strengthens outpatient teaching of child health priority problems of public health relevance, covering health promotive, preventive and clinical aspects. It helps achieve a more efficient distribution of teaching programme time on outpatient practice and the most common health problems of children in the country. By its

Box 2. IMCI pre-service education challenges

- Inadequate coordination between teaching institutions and ministries of health and between the institution departments concerned (paediatric and family and community medicine).
- Absence of this component in national IMCI plans.
- Difficulty institutionalizing it, going beyond the interest, enthusiasm and commitment of single individuals.
- Turnover of IMCI-trained teaching staff.
- Lack of standardization of teaching across the department teaching staff.
- Inclusion of some, rather than all, learning objectives, because of limited time available.
- Remaining resistance to IMCI by some teaching staff and perception of it by some as a "project".
- Difficulty developing and implementing approaches to make teaching materials available to students over time.
- Delay in including IMCI in clinical examinations.

methodology, using supervised clinical practice and standard evidence-based protocols, it enhances overall teaching quality and promotes rational use of limited health system resources.

The Regional Office has developed and is promoting a standard approach that fully involves each teaching institution eager to introduce the IMCI approach into their relevant teaching programmes. Among the key steps is the early involvement of staff of teaching institutions in the introduction of the IMCI strategy in the country, from adaptation to capacity building and follow-up. Full and close collaboration in this approach between the concerned teaching institution, ministry of health and WHO has created an effective tri-partite partnership. Advocating with professional societies, building capacity of teaching staff, conducting in-depth orientation for them, acting at both national and institutional level, are other important elements of this approach, which mostly consists of four main phases: preparatory and orientation; planning; implementation and monitoring; and review and re-planning[2]. The Regional Office has also been undertaking much development work in this area to address the needs and demands of teaching institutions and make available standard instruments, including work to develop a standard IMCI pre-service education package. This has been in addition to conducting two regional consultations on IMCI pre-service training, providing direct technical assistance to countries and institutions and evaluating the experience in two schools in Egypt and Sudan, respectively. Currently, 26 medical schools and more than 200 allied health professional teaching institutions have introduced IMCI into their programmes. Some of the measures recognized to ensure sustainability include the formal approval of introduction of IMCI by the school and departments concerned, integration into the teaching curriculum and incorporation into the departmental textbooks and student examinations. Experience in implementing the IMCI pre-service education initiative to date has also helped identify challenges that need to be addressed to support and sustain it (see Box 2).

4.1.2 Egypt experience

Alexandria University pioneered efforts in Egypt and the Region, starting in 1999. Eight medical schools have since been involved in IMCI pre-service education in Egypt (Table 1), including eight paediatric departments, two community medicine departments and one family medicine department. The approach followed was similar to the one described above. Training in IMCI of assistant lecturers has

[2] Available at http://www.emro.who.int/cah/PreServiceEducation-IMCI-Phases.htm accessed on 1 September 2007.

become a prerequisite for a doctoral degree in paediatrics in Alexandria University and has been included as part of the house officer training programme. Training teaching staff in IMCI has shown to generate more positive attitudes towards it among staff compared with those staff not trained. The practical orientation for teaching staff which has been introduced more recently has been highly appreciated. The approach used in the placement of IMCI in the overall teaching curriculum has been the "staggered approach", i.e. incorporation of IMCI-related elements throughout the curriculum, as relevant, with a synthesis block at the end, as recommended in the Region. This has been preferred to the "single block" approach—i.e. IMCI added just as one block, which has been used only in one school. Among the actions which have been critical in the Egypt experience and those of other countries in the Region which are important for the sustainability of IMCI, is the incorporation of IMCI into the core curricula of paediatrics, community medicine and nursing schools, by the Supreme Council of Universities. One limitation in building teaching staff capacity has been the dependence of teaching institutions on IMCI in-service training opportunities of the Ministry of Health and Population, which have been insufficient to address the challenge of training the many staff from teaching institutions, in addition to the turnover of those already trained.

Table 1. IMCI pre-service education: orientation and planning workshops, Egypt

Medical school	Orientation and planning workshop	Practical orientation
Alexandria	1998	2004
Al-Azhar (for boys)	2000	2003
Cairo	2000, 2002	2005
Minia	2000	–
Menoufeia	2001	–
Suez Canal	2001	–
Beni Suef	2002	–
Mansoura	–	2005

– Not conducted

A major challenge for sustainability is represented by ensuring long-term availability of teaching materials to students. IMCI notes have been developed and two universities have included an IMCI chapter in their paediatrics textbooks, purchased and used by students, ensuring com-plementarity and consistency between this chapter and other related subjects taught. Some schools have opted to print abridged versions of the IMCI chart booklet for students at low cost. Unfortunately, cost recovery approaches have not been successful.

Teaching methods employed have emphasized practical sessions and supervised clinical practice versus the traditional lecture method. Limitations include the fact that learning objectives do not cover the full scope of IMCI, leaving out the young infant, treatment and home care counselling. This is because of the limited time allocated and different coverage by different teaching units within the same

department. IMCI has been included in student examinations, enhancing student interest and its institutionalization in this way. An evaluation of IMCI pre-service education in Alexandria university has indicated that students are satisfied with the IMCI teaching approach and recommend that it be used also for teaching other subjects.

A review of the IMCI pre-service education experience in Egypt has recently led to the establishment of a national IMCI pre-service education committee, with the aim of coordinating efforts among schools and with the Ministry of Health and Population, expanding coverage to other schools, ensuring quality and sustainability and serving as a forum on IMCI pre-service education.

4.1.3 Sudan experience

A distinctive feature of the introduction of IMCI pre-service education in Sudan was the establishment of a National Medical Education Task Force in 2000 at the very start of the process. The Task Force brought together paediatricians and community physicians from seven leading medical schools, the Federal Ministry of Health (director of primary health care and national IMCI coordinator) and WHO. As seen for Egypt, this represented a good model for other countries, which then adopted it. The Task Force developed a standard approach at national level—unlike Egypt, where each school acted independently—to analyse the situation in the various medical schools, identify teaching objectives and steps for implementation, produce an IMCI national student manual for use by all universities, decide on the placement of IMCI in the teaching curricula and follow up implementation. This approach resulted in six medical schools having included IMCI in their teaching programmes, with other seven schools expressing strong interest. Furthermore, a consensus was reached to include IMCI also in the pre-service training of medical assistants, a key cadre of primary health care services in Sudan; their teaching curriculum was revised and a manual was developed. IMCI pre-service education is rightly being advocated in Sudan as part of the national human resource development plan.

As in the Egypt experience, challenges have been identified also in the Sudan experience. Medical schools have different curricula structure, the integration of community medicine and paediatric department in teaching the IMCI community component is weak, capacity building of teachers is insufficient, as are outpatient training sessions to cover student needs, and there is still some resistance to IMCI by some teaching staff, especially those not trained in IMCI. Ensuring the availability of reference and training materials to students in the long-term and updating them remains a challenge, despite a number of good initiatives carried out in the country to date.

4.2 IMCI community component: an evaluation in Morocco, an approach in Egypt and community volunteers in Sudan

4.2.1 Introduction

The "community component of the IMCI strategy" can be seen in operational terms as a package of evidence-based interventions aiming at improving key family and community child care practices. As such, it implies the adoption of multiple approaches, with involvement of different sectors and partners, to implement such interventions in a coordinated way. The practices to be addressed should be the result of a prioritization process and a few practices should be promoted at a time. The interventions to be implemented should target the determinants of the practices, rather than simply promote the practice per se. A strong link with the health system would support monitoring and supervision. Each approach should be well documented and involve the community as both a leading actor and beneficiary of the intervention. The IMCI community component is not just training of community volunteers or workers. This represents one of many approaches that should be part of a comprehensive strategy, with clear indicators and targets and a monitoring system. Over two decades of breastfeeding promotion have shown the need to combine interventions at different levels and with many partners, including for example: regulatory actions (e.g. legislation and policies), educational actions (e.g. in-service training of health providers and volunteers, pre-service education), advocacy and communication and information interventions (e.g. mass media, involvement of influential actors—including religious leaders, non-governmental organizations, etc.). Thus, only through a comprehensive and well coordinated plan can the package of interventions retain the potential to bring about the targeted behavioural changes.

Table 2. Selected results of the evaluation of the Dikha project, Morocco, 2001–2006

Practice	Rate 2001	Rate 2006	Original target
Child			
Full immunization	79%	91%	95%
Exclusive breast-feeding for 6 months	36%	50%	≥ 60%
Vitamin A and D supplementation	0%	60%	95%
Mother			
At least three antenatal care visits	6%	36%	30%
Tetanus toxoid immunization	16%	32%	60 %
Iron supplementation	9%	73%	30%
Handwashing with soap	23%	69%	70 %

4.2.2 Evaluation of the Dikha-Essaouira community experience in Morocco

The community development project in Dikha-Essaouira, Morocco, began in 2001 and was evaluated in 2006, using both quantitative and qualitative studies. It aimed, among other development objectives, to improve family practices related to maternal and child health care. The sites chosen for the project had health indicators performing less well than average and included remote areas located

more than an hour walking distance of the nearest health facility with motivated provincial and local teams. The community actively participated in the situation analysis, identification of priorities, mobilization of human and financial resources and identification of community volunteers. Volunteers were trained on priority key behaviours. Results of the evaluation relating to some maternal and child health indicators during the five-year implementation of the project are shown in Table 2. The evaluation highlighted the importance not only of community involvement but also of coordination at all levels and monitoring of implementation. It recommended among others that the Ministry of Health should play a key role in such development projects as this one since their conceptualization, placing maternal and child health at the core of them. Finally, a national strategy should be developed on behavioural change communication.

4.2.3 Developing an approach to the IMCI community component in Egypt

Community interventions require multisectoral collaboration and a long-term view, as they aim at targeting practices which are deeply rooted in one culture. Although Egypt developed a conceptual framework for the IMCI community component early in its introduction of the IMCI strategy, the focus was originally on training Ministry of Health home visitors in a long list of messages, with limited community and nongovernmental organization participation and inadequate central level monitoring. A new approach was then developed more recently aiming at communities leading efforts, prioritizing a few practices to promote at the beginning and building on ongoing community interventions as much as possible. The seven steps of the proposed process are listed in Box 3. The first two steps consist of selecting a few key family practices to promote—based on available information—and behavioural analysis to identify their underlying factors. This is compared with the feasibility and potential impact of actions and interventions targeting those factors, at both national and community level. The importance of identifying for the interventions not only the primary audience (those directly performing the practice) but also those who can influence them (secondary and tertiary audience) was emphasized in step 3. This step should lead to the identification of existing channels to deliver the interventions. Step 4 of the process is the preparation of the communication and training materials needed for the intervention, checking for consistency and appropriateness of the language for the audience, through a review of existing materials and the development of new ones as needed. Step 5 is implementation at both national and community level, with partners' consensus on interventions, materials, roles and responsibilities, and selection of the communities

Box 3. Steps of the IMCI community component approach in Egypt

1. Prioritization of key practices
2. Identification of interventions at national and community levels
3. Identification of target audience and appropriate communication channels for each practice element
4. Review / development of materials
5. Implementation
6. Monitoring
7. Evaluation and re-planning

with full governorate involvement. The key activity of monitoring is highlighted by step 6, through periodic reports from the community focal point and conduct of rapid assessments. Finally, step 7 involves evaluation against the targets originally set. The first four steps have been completed and the implementation phase is expected to start soon.

4.2.4 Community health promoters in Sudan

Community health promoters were seen in Sudan as offering the potential to bridge the gap between health system and local communities, thus also reaching out to underserved populations. The IMCI community component in Sudan initially mapped partners at national and state level and set up committees at these two levels to plan. A baseline assessment was conducted, followed by a knowledge, attitudes and practices survey to assess caretaker knowledge about key family child care practices. Cluster representatives within the Basic Development Needs (BDN) programme structure were trained. The limitations acknowledged in this initial phase were the promotion of too many practices at the same time, thus diluting efforts with weak outcome, inadequate planning and supervision, lack of coordination with other ongoing initiatives (e.g. nutrition, roll back malaria) and inability to mobilize resources. It was then decided to focus on fewer family practices to promote, revise training materials and methodology, develop a facilitator and course-director guide and monitoring tools, and increase the number of information, education and communication materials produced. Each community health promoter was responsible to visit 15 to 20 households per month. Seminars were also held. The constraints identified in this second phase were irregular supervision of promoters' work, weak reporting and inability to develop effective partnerships and mobilize resources. These constraints were to be addressed by strengthening programme management at all levels, advocating more and more effectively for the initiative with partners and developing a non-monetary motivation scheme for the community health promoters.

4.3 Scaling up IMCI: definition and approaches

Participants discussed in groups what "scaling up" IMCI means and implies. There was consensus on the fact that "scaling up" should refer to expanding both coverage and scope of the strategy. More specifically, scaling up IMCI should entail all of the following elements: a) increasing coverage for all the three components of IMCI; b) at an accelerated pace; c) preserving quality of activities; d) expanding scope (e.g. adding health child, newborn component); and d) maintaining achievements. Scaling up IMCI therefore was defined as aiming at *reaching universal coverage with all the components of IMCI at an accelerated pace of implementation according to quality standards set for IMCI, expanding the scope of the strategy to other areas as appropriate and maintaining the achievements made.* This definition intrinsically emphasizes the concept of equity.

Scaling up IMCI, as defined above, would have good chances of succeeding if the following elements are in place:

- a comprehensive *national policy* on child health with a strategy for implementation or at least *one strategic IMCI country plan* owned by the government with clearly defined indicators and targets, to the implementation of which all partners can contribute;

- *effective commitment*, with allocation of the required human and financial resources, institutionalization of IMCI in the ministry of health organigram and a budget line for IMCI-related activities in the ministry of health budget;

- a *systematic and standardized approach* to the implementation of each main step, as spelt out in the strategy document, including standard operating procedures for implementation setting quality standards;

- *IMCI pre-service education* in place in medical and allied health professional schools;

- strong *advocacy*, including information sharing, to mobilize the necessary support and strengthen partnerships;

- *documentation of activities, regular monitoring and periodic evaluation*, to adapt implementation as needed and maintain quality standards throughout;

- *technical support from WHO.*

Other important elements identified were: strong *coordination* with all partners involved; strengthening provincial (governorate) and *district capacity* for implementation; identification of *alternative approaches* to implementation (e.g. alternative approaches to the 11-day IMCI training course, while maintaining the same quality and outcome; mobile teams to deliver services to remote areas); including IMCI in *continuing medical education* (CME) and *accreditation* requirements for licensing or renewal of licences and for medical schools; and *linking IMCI to other initiatives* (e.g. quality assurance programmes, Global Alliance for Vaccines and Immunization (GAVI) Health Systems Strengthening, Global Fund for AIDS, TB and Malaria (GFATM).

5. IMCI UPDATES

5.1 Improving newborn health through IMCI

Infections, including sepsis, pneumonia, tetanus and diarrhoea, are responsible globally for 36% of neonatal deaths, followed by pre-term conditions (27%) and asphyxia (23%), as the most common causes of neonatal death. As almost

30% of neonatal deaths occur on the day of birth and over 70% of deaths occur during the first week of life, birth and the first week of life are critical, considering also that coverage of interventions is low. The health of the mother and newborn

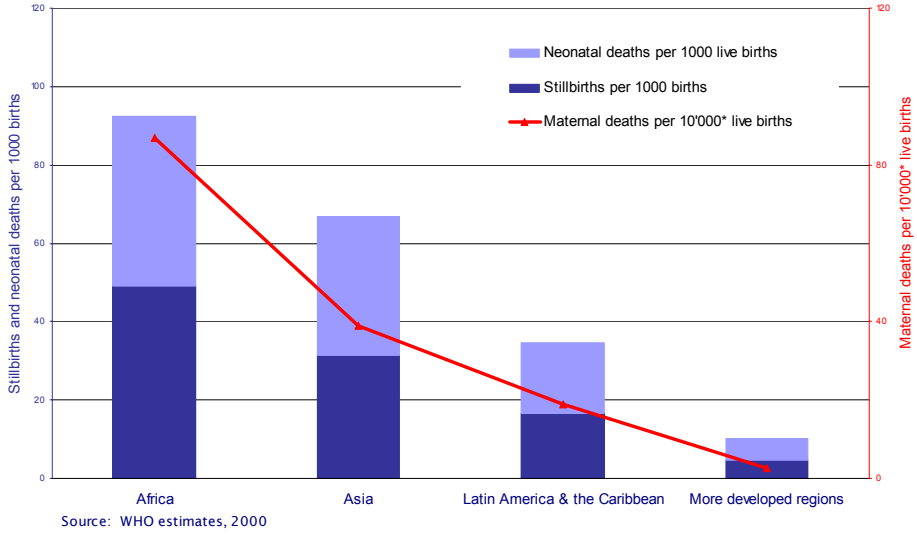

Figure 3 Relationship of maternal deaths with neonatal deaths

baby are inseparable (Figure 3). Effective interventions for newborn health exist, including those to prevent and treat infections, address pre-term conditions and low birth weight, and asphyxia, in a continuum of care from pregnancy to the postnatal period. It has been estimated that prenatal interventions would reduce 8% of neonatal deaths, intrapartum interventions 27% and postnatal interventions 29%. Of these, interventions delivered as clinical services would reduce 37% of neonatal deaths, outreach services 8% and community interventions 24%.

Effective interventions through IMCI at health facilities include:

- essential interventions for all neonates, such as assessment of neonatal well being; support for early initiation of breastfeeding and exclusive breastfeeding, thermal care and hygienic cord care; advice on danger signs and prompt care-seeking; immunization; identification of neonates needing additional care;

- additional care for low birth weight babies;

- management of neonatal illness, including severe illness, feeding problems, local infections; and

- other interventions according to the setting (HIV interventions, use of insecticide-treated bednets).

The IMCI guidelines cover the first week of life in eight countries in the Region. The WHO generic guidelines have recently been updated on the identification of severe illness (fewer signs with high sensitivity and specificity) and

support for feeding and skin-to-skin care. Jaundice is included in four countries in the Region, while a review of data is being undertaken.

Effective interventions through IMCI in the community include promotion of antenatal visits, tetanus toxoid immunization, intermittent preventive treatment for prophylaxis against malaria during pregnancy and the other essential neonate interventions described above.

As the first week of life is critical, postnatal visits should be conducted in the first 24 hours after birth, on day 2–3 and 6–7 and 4–6 weeks after delivery to counsel on vaccination and birth spacing. More frequent visits are recommended for low birth weight babies.

Finally, a strategic framework to plan for neonatal health was presented (Box 4).

Box 4. Planning to strengthen newborn health: a strategic framework

A committee: IMCI task force and maternal health
↓
Situation analysis
↓
Discuss situation analysis findings and assess opportunities and gaps
↓
Prioritizing and phasing interventions / packages
↓
Development of implementation strategy, M&E* plan
↓
Assimilation into Maternal and Child Health Programmes

* M&E: Monitoring and Evaluation

5.2 IMCI technical updates on treatment

The updates concerned the treatment of severe and non-severe pneumonia, management of diarrhoea and treatment of fever/malaria, ear infections and helminthiasis. Major treatment novelties included: the 3-day therapy with oral antibiotics (amoxicillin or cotrimoxazole) shown to be as effective as the 5-day course in the management of children 2–59 months old with non-severe pneumonia (in low HIV prevalence settings), with a twice daily administration of amoxicillin as a feasible alternative to 3–day administration; the preference for injectable ampicillin plus gentamicin for very severe pneumonia in children 2-59 months of age versus parenteral chloramphenicol; the use of low-osmolarity ORS and benefits of zinc supplementation; the preference for artemisin-based combination therapies (ACT) to

Box 5. Introducing new IMCI recommendations in countries

- Identifying key stakeholders
  - Ministry of health
  - Professional organizations and leading pediatricians
  - Partners
  - Private sector and other decision makers
- Presenting scientific evidence
- Endorsing the new recommendations
- Revising/updating policy guidelines
- Reflecting changes in standards of care including training materials
- Deciding how to transmit or disseminate updates to health providers and trainers already trained in IMCI.

treat malaria in most areas (together with diagnosis by microscopy or rapid tests); the adjunct of topical antibiotics (e.g. ciprofloxacin, chloramphenicol, gentamicin) to aural toilet in the management of chronic ear infections; and regular deworming with albendazole and mebendazole in children starting from 12 months of age rather than 24 months[3]. One of the objectives of the presentation of these updates in small groups was to discuss how to translate these new recommendations into actions in countries (Box 5). WHO policy statements and guidelines to support countries were reviewed.

5.3 Promotion of infant and young child feeding under the umbrella of IMCI

Malnutrition is associated with 53% of all childhood deaths. The risk of inappropriate feeding is highest in the first days and weeks of life and the incidence of stunting rises sharply after six months of age. Optimal exclusive breastfeeding is one of the most cost-effective child care practices, able to prevent 13% of under-five deaths; yet, rates remain low in countries in the Region. Infant and young child feeding is at the core of the IMCI strategy. Special attention is given to breastfeeding in the Region in the areas of:

- strengthening legislation and policies, ensuring that infant and young child feeding is incorporated in national child health policies;
- human resource development, through the recently developed regional training package and initiatives on counselling, introduction of child feeding into the teaching curricula of medical schools and in a training module on health child;
- health system strengthening, promoting the establishment of breastfeeding promotion clinics and healthy child clinics, monitoring and integrated supervision;
- community component to improve family child care practices and support to breastfeeding mothers.

[3] These updates are described in detail in "Technical updates of the guidelines on Integrated Management of Childhood Illness (IMCI) - Evidence and recommendations for further adaptations", WHO, Geneva, 2005 [ISBN 92 4 159348 2], available at http://www.who.int/child_adolescent_health/documents/9241593482/en/index.html (accessed on 9 March 2008).

Regional strategic directions recognize the importance of coordination because of the need for multisectoral interventions, promote measures to implement the International Code of Marketing of Breastmilk Substitutes and legislation to protect breastfeeding rights of working women. WHO has developed new child growth standards, with breastfeeding as the normative model and providing a link between physical growth and motor development.

5.4 Research on guidelines on the management of poisoning and burns in young children at primary health care level

Injuries are a growing and largely preventable public health problem, responsible for 3% of all under-five deaths globally and representing one of the leading causes of death in children 1 to 4 years old in some countries in the Region. For every death, there are many consultations, hospital admissions and permanent disabilities, which give injuries a high "cost" for individuals, families and the society. Together with falls and drowning, poisoning and burns are major contributors to the burden of injury in children. Mortality rates in children under five related to unintentional poisoning are virtually the highest among all age groups in the Eastern Mediterranean Region. Many cases go unreported. Also, burn statistics include fire burns but not scalds, which are the most common type of burn. Management of poisoning and burns at primary health care level often lacks clear guidelines, resulting in under- and over-treatment and inefficient use of resources.

Developmental work on the management of poisoning and burns envisaged two phases: a) "curative", to develop standard clinical guidelines for use at primary health care level in developing countries, with a format similar to the IMCI guidelines; and b) "preventive", dealing with community interventions to prevent unintentional poisoning and burns in children under five.

Key steps in the development of the clinical decision instrument include the derivation of the rule for the early identification of cases needing referral and its validation in other settings together with provider performance analysis. The guidelines should be safe and effective and follow a number of principles as outlined also for the IMCI algorithm. Namely they should: follow the simple assess–classify–treat system; include a minimum number of highly sensitive and specific clinical signs; require only simple skills to use; be able to be effectively taught and learned; require a minimum number of essential medicines; and provide the best care possible for severe cases.

A prospective study was conducted at a Poison Control Centre enrolling children under five presenting within two hours of exposure to hydrocarbons (n=256 children, from February to December 2004) and organophosphates or carbamates (n=95 children from February 2004 to October 2005). All children were admitted for close follow-up at 6, 12, 24 and, if still present, 48 hours post-exposure. In line with the principles described above, the study identified: in children exposed to hydrocarbons, three clinical signs (wheezing, alteration in

consciousness and fast breathing) that, if present within two hours of exposure, may help differentiate between children requiring higher level resources (referral) from those not requiring them (sensitivity 98% and specificity 42%); and, in children exposed to organophosphates/carbamates, two clinical signs (pinpoint pupils and diarrhoea) (sensitivity 100% and specificity 77%). The rules derived through this study will need to be validated in other settings. The findings were presented at the North American Congresses of Clinical Toxicology in September 2005 (hydrocarbons)—Clinical Toxicology 2005; 43:634—and October 2006 (organophosphates/carbamates)—Clinical Toxicology 2006, 44:716—and then submitted for publication in full.

The development of the clinical decision instrument for burns was based first on expert review. The rule was initially drafted based on current international protocols and then reviewed by many burn centres and experts within and outside the Region also through a technical e-discussion group. A technical review paper on the technical basis of the rule and gaps was prepared, while waiting also for the results of a Cochrane review of honey used as a topical treatment for wounds. Photographic and clinical materials to develop a visual library of burn cases were collected from a burn centre. The instrument will need to be tested to collect additional information to address some of the information gaps identified by the technical paper.

Constraints for continued work in these areas have been in the identification of suitable settings for the validation of the clinical decision instruments—settings with high caseload and documented research capacity—and lack of resources.

6. INSTITUTIONALIZING IMCI AS PRIMARY CHILD HEALTH CARE STRATEGY

It is widely agreed that IMCI needs to be institutionalized in ministries of health to receive the necessary support to accomplish universal coverage and sustain achievements. Various programmes dealing with child health should be brought together in a child health unit or department, to integrate and/or coordinate them more effectively. A child health management structure should be an integral part of the ministry of health organigram, possibly placed under the primary health care section. One country plan on child health should be developed, to which all partners can contribute. A government budget line should be established to support key activities related to child health and other agencies' funds, including WHO, should be aligned and allocated to concretely reflect the commitment to the achievement of the Millennium Development Goal # 4 on child mortality reduction as a priority.

There is no doubt that much advocacy will be required for this purpose, in an increasingly competing environment. Efforts will need to aim at "visibility", bringing evidence, through good documentation of experiences, strong and regular data and sound evaluations.

7. MONITORING IMCI

7.1 Child health indicators

There is a need to agree on a set of selected indicators on which countries can report regularly using standard definitions. Indicators are numbers, proportions, percentages or rates used to monitor what has been done ("process and outputs") and what this has led to ("outcomes and impact"). It is important to go beyond the "process" and include "outcomes" to understand whether countries are on the right track so as to adjust plans accordingly. This information is also key to advocacy to draw interest, mobilize resources and obtain the required political support. The principles followed in the selection of what should be monitored should refer to universal coverage and equity. It would be of practical value to report on indicators at various levels, such as province (governorate, state), district, primary health care facility and population.

Within the health system, it is important to identify a number of indicators describing the capacity at health facility, district and provincial level to provide IMCI care services and the capacity to provide counselling on feeding, including breastfeeding. It was proposed that, at health facility level, capacity for IMCI care would refer to facilities with staff trained in IMCI and regularly supplied with key essential medicines, as a proxy indicator. Detailed definitions on "IMCI training", "regularly supplied" and "essential medicines" were discussed. A ratio was proposed to define feeding counselling capacity, relating number of staff trained to the under-five population served in a country. In addition to these indicators, other indicators were proposed to monitor whether children under five would be receiving appropriate care (e.g. severe cases urgently referred, children with non-severe pneumonia correctly managed) and caretakers would leave the facility with correct knowledge about treatment of infections and home care (e.g. antibiotic and antimalarial treatment, ORS and fluids and continue feeding for children with diarrhoea, respiratory signs to seek care for children with acute respiratory infections). The rationale for caretaker knowledge was that caretakers were ultimately those providing care to children in all non-severe cases and it was therefore crucial to monitor the proportion of them who would leave a health facility with clear understanding about what to do at home, as this would increase the chances of their providing proper care to their children. Other possible indicators were briefly discussed on immunization, vitamin A supplementation and utilization of services.

Indicators at household level had already been identified in global consultations and relevant information was to be collected periodically when conducting planned national surveys such as demographic and health surveys (DHS), multiple-indicator cluster surveys (MICS) or as in the Pan Arab Project for Family Health (PAPFAM), or smaller scale household surveys.

There was much interest in discussing the proposed indicators, in relation to their practical value, availability of instruments and resources, feasibility of collection and timely reporting within the country and to WHO. Participants acknowledged that this was a very important area and a few days would be needed to discuss the proposed list in detail also in view of the diversity of the country situations. To achieve consensus on which indicators to report and which tools to use to collect that information, participants strongly proposed that an ad hoc consultation be conducted for that particular purpose.

7.2 Child epidemiological country profiles

The objective of developing under-five epidemiological country profiles is to provide the best available information for evidence-based action-oriented decisions on policies, strategies and implementation, eventually influencing the health status of under-five children. As noted earlier, this information would be a solid basis for advocacy and resource mobilization. The information presented in the profile on the main conditions affecting children, health outcomes and coverage of interventions, and inequities in outcomes and coverage would help in understanding the situation, setting priorities based on needs, assessing progress over time, advocating for investments and allowing international comparisons.

The data to be collected relate to indicators on health status (deaths—rates, trends, causes, inequities, morbidity and malnutrition), outcomes (coverage in interventions, inequities and quality of care), outputs (access to health care) and inputs (health policies and financing). Sources need to be reliable and range from vital registration systems to nationally representative surveys, IMCI reporting data, government and partners' information and national health accounts.

It is recognized that this effort faces many challenges. WHO can collaborate with a few countries to assist in the development of the respective country profiles and organize capacity-building workshops.

8. CONCLUSIONS

- 10 years of IMCI implementation in the Region and at global level have shown that IMCI is a cost-effective strategy that responds well to the needs of children under five.

- IMCI is acknowledged in the Region as a broad primary child health care strategy for children under five.

- IMCI is a dynamic and flexible strategy that brings quality to under-five child health care and is able to adapt to evolving country needs. In the Region, many countries have adapted IMCI to include care for the neonate at first level, healthy children and psychosocial development.

- Improving infant and young child feeding practices (including breastfeeding) has been recognized as an essential intervention to protect, promote and improve child health and development (including neonates)

- Experience in the Region has showed that scaling up the IMCI strategy is feasible with adequate political commitment and matching resources.

- The lack of national child health policies strongly contributes to the lack of commitment to child health and adversely affects the harmonization and coordination of actions between relevant stakeholders.

- Country experiences have pointed out that child health related efforts are fragmented and dispersed among different programme areas and partners. This makes the use of available resources less effective and adversely affects the rate of scaling-up.

- Partnerships between child health related programmes, academia, community and other relevant partners, including nongovernmental organizations and the private sector, are being built and expanded.

- Progress of scaling up IMCI in the Region has been uneven. Essential conditions and ways to accelerate progress in implementation in order to achieve MDG4 were identified during the meeting.

- The Region has been pioneering the implementation of IMCI pre-service education. The growing interest of countries in the initiative shows that IMCI pre-service education is recognized as an essential prerequisite for IMCI sustainability and scaling-up.

- The IMCI community component has been moving at a slower pace than the other two components but there are encouraging country experiences that may guide future work in this area.

- The identification and measurement of key indicators are essential to assess progress, plan and advocate for increased commitment and resources.

- WHO technical support has been highly valued by countries and recognized as a key factor in accelerating progress of IMCI implementation.

- Collaboration with other partners, in particular UNICEF, is also recognized as a major factor for the progress made.

- Participants expressed clear appreciation for the opportunity that this meeting created to share experiences with other countries, discuss issues of common interest and jointly identify ways to move forward.

9. RECOMMENDATIONS

To Member States

1. Develop a comprehensive child health policy, with emphasis on children under-five that specifies all child health elements, which should serve as a basis for all relevant stakeholders to develop strategy and work plans.

2. Plan to expand the scope of the IMCI strategy to address under-five child health rather than only illness.

3. Increase emphasis on neonatal care within the three IMCI components and strengthen linkages with maternal health and other relevant programmes to ensure continuum of care.

4. Plan for scaling up the IMCI strategy to achieve universal coverage, while maintaining quality, following a systematic approach.

5. Develop and fully own one national plan for all IMCI components, with clear indicators, timely-bound targets and adequate allocation of human and financial resources, to which all partners will contribute.

6. Include actions to promote infant and young child feeding practices using available tools as an integral part of the IMCI plans of action.

7. Include IMCI pre-service education as an integral part of national IMCI plans, intensify efforts to scale up its implementation and evaluate it.

8. Regularly monitor progress, including inputs, outputs and outcomes of IMCI implementation, complemented by periodic evaluations to measure impact.

9. Carefully document experiences and use the successes and lessons learnt to advocate for increased commitment, support and resources (financial and human).

10. Regularly report to WHO information on IMCI progress.

To WHO

11. Continue providing all possible technical support to countries, including the development of tools adapted to the needs of the Region.

12. Develop a framework for monitoring and evaluation and agree with countries on key indicators and standardized procedures for reporting.

13. Ensure that within the regular budget, adequate resources are allocated to child health at country and regional levels.

14. Continue to fulfil a coordinating role to build partnerships for child health in the Region.

15. Convene periodic intercountry meetings on child health (IMCI) to discuss technical and programmatic issues and review overall progress in countries in the Region.

Annex 1

PROGRAMME

Sunday, 2 September 2007

08.30 - 09.30	Registration
09.30 - 09.45	Address by Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean
09.45 - 10.00	Speech by Dr Jose Martines, Coordinator of Newborn and Child Health and Development, CAH/HQ
10.00 - 10.30	Address by H.E Dr Ali Assa'ad, Acting Minister of Health of Jordan
10.30 - 10.45	Overview of IMCI implementation in the Region: 10 Years of IMCI in the Eastern Mediterranean Region (Dr Suzanne Farhoud, RA/CAH/EMRO)
10.45 - 11.00	15-minute documentary on 10 years of IMCI in the Eastern Mediterranean Region
11.00 - 11.30	Participant introduction

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	SESSION 1: IMCI IMPLEMENTATION STATUS
12.00 - 12.30	IMCI global implementation status and impact (Dr Jose Martines, CAH/HQ) Discussion
	SESSION 2: APPROACHES TO IMCI SCALING-UP
12.30 - 13.00	Scaling up IMCI towards universal coverage: The approach - Egypt experience (Ministry of Health and Population, Egypt) Discussion
13.00 - 13.30	Status of IMCI implementation and new directions: The role of political commitment and strong partnerships - Pakistan experience (Federal Ministry of Health and Aga Khan Health Services, Chief Executive Officer, Pakistan) Discussion
13.30 - 14.00	Scaling up IMCI in a country facing challenging circumstances: Role of Government and NGOs - Afghanistan experience (Ministry of Health, Afghanistan) Discussion

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15.00 - 18.00 Group work 1: Why we are where we are: much progress in some countries in some programme areas and little progress in others

Monday, 3 September 2007

	SESSION 2: APPROACHES TO IMCI SCALING-UP *(continued)*
09.00 - 10.00	Group work 1: Plenary session
	SESSION 3: BEYOND REACHING UNIVERSAL COVERAGE:
	A. IMCI SUSTAINABILITY
	Achievements need to be sustained: IMCI sustainability
	A.1. IMCI pre-service education
10.00 - 10.30	Regional experience on IMCI pre-service education (Dr Suzanne Farhoud, RA/CAH/EMRO)
10.30 - 11.00	IMCI pre-service training: the way forward - Egypt experience, (Ministry of Health and Population, Egypt)
	Discussion

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11.30 - 12.00	IMCI pre-service training: the way forward - Sudan experience (Federal Ministry of Health, Sudan)
	Discussion
	A.2. Community component
12.00 - 12.15	IMCI community component: definition (Dr Suzanne Farhoud, RA/CAH/EMRO)
12.15 - 13.30	Approaches to the IMCI community component: Evaluation of the interventions - Morocco experience (Ministry of Health, Morocco)
	Discussion
	Developing an approach - Egypt experience (Ministry of Health and Population, Egypt)
	Discussion
	Role of community volunteers - Sudan experience (Federal Ministry of Health, Sudan)
	Discussion

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	A.3. Involvement of the private sector
14.30 - 14.45	Partnership: Role of private sector in the Region (CAH/EMRO)
14.45 - 17.00	Group work 2: How can we move towards accelerated quality implementation of IMCI?

Tuesday, 4 September 2007

	SESSION 3: BEYOND REACHING UNIVERSAL COVERAGE: A. IMCI SUSTAINABILITY (c*ontinued*)
09.00 – 10.00	Group work 2**:** Plenary session
	SESSION 4: BEYOND REACHING UNIVERSAL COVERAGE: B. UPDATING IMCI
	IMCI is a dynamic strategy: updating IMCI
10.00 - 11.00	Group work 3: IMCI updates ▪ Neonatal component of IMCI ▪ New guidelines of treatment
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11.30 - 13.00	Group work 3: IMCI updates (*continued*) ▪ Infant and young child feeding component of IMCI ▪ EMRO IMCI Pre-service education evaluation guide
13.00 - 13.15	Research on guidelines of management of poisoning and burns in young children at PHC level (Dr Sergio Pièche, MO/CAH/EMRO)
13.15 - 13.30	CAH EMRO website: Sharing information and experiences (Dr Sergio Pièche, MO/CAH/EMRO)
	SESSION 5: ADOPTING IMCI AS PRIMARY CHILD HEALTH CARE STRATEGY
13.30 - 13.45	IMCI is the primary child health care strategy in the Region (Dr Suzanne Farhoud, RA/CAH/EMRO) Discussion
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14.45 - 16.00	Group work 4: How to adopt and institutionalize IMCI as primary child health care and include it among the top priorities of countries
16.00 - 16.30	Group work 4: Plenary session

Wednesday, 5 September 2007

SESSION 6: REPORTING ON CHILD HEALTH ACTIVITIES AND IMCI IMPLEMENTATION IN COUNTRIES

09.00 - 09.30 Child health indicators (Dr Sergio Pièche, MO/CAH/EMRO)

09.30 - 10.30 Group work 5: Discussion of child health indicators and mechanisms of reporting

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11.00 – 13.30 Group work 5: Discussion of child health indicators and mechanisms of reporting (*continued*)

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14.30 - 16.00 Market place

16.00 - 16.15 Group work 5: Plenary session

16.15 - 16.30 Child health country profile (Dr Bernadette Daelmans, CAH/HQ)
Discussion

Thursday, 6 September 2007

09.00 - 11.00 Planning for moving forward IMCI implementation as the primary child health care strategy, including measures for institutionalization: preparation of country plans

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11.30 - 12.30 Review of country plans

12.30 - 13.30 Conclusions and recommendations
Closing session

Annex 2

LIST OF PARTICIPANTS

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Annex 3

SUMMARY OF MAIN RECOMMENDATIONS IN WHO/EMRO REGIONAL EVENTS, 2000—2007

Main recommendations to countries

- The recognition of child health as a priority should be reflected in the development of a comprehensive child health policy.
- The process recommended by EMRO for child health policy development should guide countries in formulating their policy.
- IMCI should be seen as a "primary child health care strategy" with effective interventions (including child feeding) and as a key strategy to achieving child health-related MDGs.
- Partnerships should be established or strengthened.
- Planning should be based on evidence.
- Investments should be made in all the three IMCI components to obtain the full benefit of IMCI.
- Management should be decentralized to sustain and scale up IMCI
- Ministries of health and teaching institutions should collaborate closely from the early stages of IMCI introduction.
- Any effort should be made to institutionalize IMCI into the pre-service education teaching programmes as an approach to ensure IMCI sustainability and strengthen teaching of public health approaches.
- Country experiences and lessons learnt should be well documented and shared regularly with the Regional Office.
- Advocacy should be an ongoing focused process, based on information to obtain and maintain commitment, build partnerships and generate resources.
- Political commitment to child health should be translated into action, with allocation of adequate human and financial resources, to ensure equitable access of all children to quality health care services.

Main recommendations to WHO

- Expand the focus from illness to child health.
- Advocate for priority to be given to and investment to be made in child health by government and partners.
- Play a leading role in coordinating partners' work in child health.
- Develop tools and guidelines.
- Assist in planning, implementation, monitoring and evaluation of IMCI implementation.
- Support research to generate evidence.
- Share information and country experiences.