THE ANALYTIC REVIEW

OF THE
INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS
STRATEGY

Final Report
November 2003

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This report contains the collective views of an international group of experts, and does not necessarily represent the decisions, or the stated policy of the World Health Organization.

This report has been prepared on behalf of the Analytic Review team by Thierry Lambrechts (WHO), Rajiv Bahl (WHO), David Robinson (DFID Consultant), Samira Aboubaker (WHO), and Oscar Picazo (USAID funded AED/SARA Project), with input from Joy Riggs Perla (USAID Consultant), Maria Francisco (USAID), and Al Bartlett (USAID).

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Executive Summary

The Integrated Management of Childhood Ill ness (IMCI) strategy to reduce childhood mortality and morbidity has three components: improving health worker skills; strengthening the health system; and improving family and community practices.

In 2002, DFID, UNICEF, USAID, and WHO conducted an Analytic Review to identify the contribution of the IMCI strategy to improved child health outcomes and actions required to achieve greater coverage and impact. The findings and recommendations are based on a desk review, interviews with national and international informants, and an assessment of IMCI implementation experience in Egypt, Kazakhstan, Indonesia, Mali, Peru and Zambia.

RECOMMENDATIONS FOR COUNTRIES AND INTERNATIONAL PARTNERS

Support development of policies and interventions based on national context and priorities

- Countries, with the participation of implementing partners, should develop national policies and strategies that set child health priorities, define roles of IMCI and other key child health interventions, highlight links between those interventions, and identify appropriate delivery mechanisms.
- Health authorities at country and international level, with the support of partners, should analyse the impact of critical health system constraints on child health outcomes and address these constraints in plans for health system strengthening. These constraints should also be addressed in the situation analyses undertaken by the Ottawa Child Survival Partnership and brought to the High Level Forum and other international fora.
- Additional strategies including communication, social marketing, and other approaches should be implemented to complement traditional public health sector approaches, in order to accelerate achievement of improved child health and nutrition outcomes.

Better define the IMCI strategy, its scope and content and develop missing tools

- Each country should better define the position, role, and structure of IMCI, including the community component, in its health systems.
- WHO, UNICEF and implementing partners should increase IMCI effectiveness by providing additional elements, such as tools for and training in child health programme management, an IEC guide and approaches to monitor child health outcomes at household level using existing tools (e.g. over-sampling of IMCI areas when conducting DHS or MICS surveys) and/or an IMCI-related household survey instrument.
- Adaptations and innovations to IMCI training should be encouraged and evaluated in order to increase coverage while maintaining quality.
- As evidence becomes available for additional interventions in key areas of child health, such as neonatal health and HIV, countries, with support of WHO, UNICEF and implementing partners, should evaluate the potential role of IMCI and other approaches in delivering these additional interventions.

RECOMMENDATIONS FOR COUNTRIES AND INTERNATIONAL PARTNERS (continued)

Provide support for scale up of child health programmes and IMCI

- Considering the strengths of the IMCI strategy and the existing commitment and investment by countries, the IMCI strategy, with relevant improvements, should be continued and expanded, as part of a broader investment approach to improve child health outcomes.
- Countries and implementing partners should increase urgently the resources (human, financial, external and internal) devoted to child health programmes and make better use of existing financial and human resources (HIPC, PRSPs, private for-profit sector, communities) in order to achieve the under-five MDG targets in countries.
- Countries and implementing partners should provide adequate resources and mechanisms to monitor progress on key child health outcomes and use this information for managing child health programmes and resources.

Key Findings

Context

Causes of child mortality

With the exception of perinatal conditions, the leading causes of child mortality remain those covered in the IMCI case management guidelines. HIV/AIDS is an emerging cause of childhood death in sub-Saharan Africa. Malnutrition is widespread. Other key determinants of child mortality include maternal education, access to antenatal and delivery care, and access to safe water and sanitation. National data hide significant and widening economic, geographic and ethnic inequities; these inequities are a major obstacle to reducing child mortality.

Child health policies and financing

The MDGs are perceived as international rather than national goals. While national policies prioritise aspects of child health, notably immunisation, most countries do not have comprehensive child health policies. Child health, with the exception of raising immunisation rates, receives limited attention in Poverty Reduction Strategies.

Allocation of national government financing for child health within overall health services funding is hard to ascertain. In general, child health suffers from inadequate government funding, and financing is reliant on donor support . Child health is not adequately addressed in new financing modalities such as sector wide approaches, budget support and debt relief. The potential impact on child health of increased resources available through the Highly Indebted Poor Countries' Initiative is unclear.

Accurate information about global financial resources for child health and trends in global funding is not available. However, specific funding allocations for child health have declined as donors shift to sector wide approaches and increase allocations to HIV/AIDS. Child health may benefit from additional resources made available through disease-specific global initiatives such as the Global Fund and Roll Back Malaria in countries where these diseases are significant problems. In other countries these initiatives may skew priorities, with an adverse effect on child health.

Health systems

Low utilisation of public health services is a major obstacle to reducing child mortality. Barriers include treatment and transport costs, perceptions about poor quality of services, lack of drugs, and behavioural and cultural factors. The impact of health system decentralisation on child health is unclear. Capacity to plan and implement child health programmes at district level needs to be strengthened to maximise the benefits of shifting resources and decision-making closer to users.

Use of private providers depends on country context; existing evidence suggests that in many countries the

role of such providers is substantial. No data are available to indicate what proportion of out of pocket expenditure on health is for childhood illness. The potential of the private sector, including NGOs, to deliver child health care and commodities is not considered systematically in national health plans.

Integrated Management of Childhood Illness

Perceptions of IMCI

Technical approach – The child health interventions included in IMCI are recognised to be technically sound; the holistic approach to child health and the conceptual framework for community interventions are appreciated; and the case management guidelines are acknowledged as good evidence-based standards for child care practice. The IMCI strategy does not cover perinatal care and covers only partially infant and young child feeding and immunisation; some countries have successfully adapted the generic case management guidelines to include these issues.

Conceptual understanding – There is a lack of clear understanding of some elements of the IMCI strategy, especially community interventions, of how the three components can best be implemented, and of what IMCI can be expected to deliver.

Implementation of IMCI

Integration of the three components – So far, none of the countries were implementing all three IMCI components in full or in an integrated manner. Most have focused on improving health worker skills; in some contexts IMCI is perceived to be a training programme. Less attention has been paid to the health systems strengthening and community components. Tools for these components were developed after tools for training.

Coverage – IMCI coverage is low, and this is attributed to lack of financial and human resources and poor working conditions with high turnover of health workers.

Coordination – Coordination during the initial phase of IMCI implementation has not been sustained. Despite mechanisms for coordination of implementing partners, there is little evidence of harmonised planning and monitoring or technical and financial inputs. Collaboration with EPI programmes is limited. There is collaboration with malaria control programmes on IMCI case management guidelines and training, and community activities.

Contribution of IMCI

Improving health worker skills – IMCI training is effective, improving health worker performance and motivation, quality of care delivered to sick children attending first level public health facilities, and caretaker satisfaction. There is evidence that it can im-