UNITED REPUBLIC OF TANZANIA

Strategy for the implementation of Integrated Management of Childhood Illness

July 1998 - June 2003

Ministry of Health

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LIST OF ABBREVIATIONS

AMO	= Assistant Medical Officer
ARI	= Acute Respiratory Infections
BFHI	= Baby friendly Hospital Initiative
CA	= Clinical Assistant
CBHC	= Community Based Health Care
CD	= Course Director
CDD	= Control of Diarrhoeal Diseases
CHF	= Community Health Fund
CI	= Clinical Instructor
CO	= Clinical Officer
CSSC	= Christian Social Services Commission
DHMT	= District Health Management Team
DMO	= District Medical Officer
DPS	= Director Preventive Services
EDP	= Essential Drugs Programme
EPI	= Expanded Programme on Immunization
FAMS	= Financial, Administration and Management Support training
GTZ	= Gesellschaft Fuer Technische Zusammenarbeit
HEU	= Health Education Unit
HESAWA	= Health, Environmental Sanitation and Water
HMIS	= Health Management Information System
IDRC	= International Development and Research Cooperation
IMCI	= Integrated Management of Childhood Illness
ITN	= Insecticide Treated Nets
MO	= Medical Officer
MoH	= Ministry of Health
MUCHS	= Muhimbili University College of Health Sciences
NEDLIST	= National Essential Drug List
NHSR	= National Health Sector Reforms
PAT	= Paediatric Association of Tanzania
PSU	= Pharmaceutical Support Unit
RCHU	= Reproductive and Child Health Unit
RHMT	= Regional Health Management Team
RMO	= Regional Medical Officer
TEHIP	= Tanzania Essential Health Interventions Project
TFNC	= Tanzania Food and Nutrition Centre
ToT	= Training of trainers course
UNICEF	= United Nations Children's Fund
WB	= World Bank
WHO	= World Health Organisation

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FOREWORD

This strategy was developed during a two week review and planning meeting with contributions from different people (MoH officials, representatives of regions, districts and schools implementing IMCI, NGOs and partners like UNICEF, WHO, TEHIP, GTZ) in order to guide implementation of IMCI in the country, a strategy which started being implemented since 1996.

I would like to acknowledge their assistance in the production of this valuable document, which will serve as a guideline for the implementation of IMCI in the country.

Let me take this opportunity also to congratulate the reviewers of the early implementation of IMCI in Tanzania for producing guidelines on IMCI activities in order to contribute to the reduction of mortality and morbidity associated with major causes of childhood illness such as malaria, pneumonia, diarrhoea, measles and malnutrition.

The strategy has covered the key priority areas and has clearly stipulated the strategies, objectives and activities including monitoring and evaluation.

I would like to emphasise that for this strategy to be successful, the Ministry of Health, various Government Ministries, partners, private sector, NGOs and other agencies need to collaborate and participate fully on the implementation of all the components of IMCI.

It is the hope of the Ministry of Health that this framework will provide effective guidelines on management of childhood illness and implementation of the IMCI strategy in general.

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ACKNOWLEDGEMENTS

This strategy document was developed during a two week review and planning meeting, with contributions from different people. These include: Ministry of Health officials, representatives of regions, districts and schools where IMCI is being implemented, NGO's and partners, such as WHO, UNICEF, TEHIP, GTZ and CSSC. In the first week achievements in the first 2 years of IMCI implementation were reviewed, constraints identified, possible solutions proposed, and recommendations made. In the week immediately following the review, these recommendations were used to develop the current strategy document. Without the invaluable contribution of all the participants, this document could not be possible with such a good quality. Sincere thanks to all.

The Ministry of Health would like to acknowledge the technical input for developing this strategy provided by Technical consultants from WHO/AFRO , IMCI, WHO CAH/HQ and UNICEF. Other members are also thanked for invaluable comments and ideas.

The Ministry further acknowledges the financial support provided by WHO, UNICEF, GTZ and TEHIP that enabled the meeting to take place.

1. BACKGROUND

1.1. Health policy of Tanzania

Tanzania has a population of 30 million people of which 6 million are children under 5 years of age. It has an infant mortality of 88 per 1000 and under 5 mortality of 137 per 1000 (Demographic Health Survey, mainland Tanzania 1996). The major causes of childhood morbidity and mortality are malaria, ARI (mainly pneumonia), diarrhoea, malnutrition, and measles.
In its efforts to improve child survival, the Ministry of Health of Tanzania developed specific disease control programmes and policies, which have been operational since the 1980s.

The overall objective of Health Policy in Tanzania is to improve the health and well-being of all Tanzanians with a focus on those most at risk which include infants and children under 5 years of age. In addition it seeks to encourage the health system to be more responsive to the needs of the people. In line with this objective the country is undergoing decentralization and Health Sector Reforms which aim at improving the quality of care and equity. The strategy document for implementing HSR has been developed and is currently being piloted. IMCI has been incorporated into HSR as a strategy for improved child care.

In 1994 the late Minister of Health, Honourable A. Mayagila wrote to WHO a letter of commitment to the Sick Child Initiative, adopting this as a strategy for reducing childhood mortality in Tanzania. Since then, IMCI implementation started in the country under the coordination of the Directorate of Preventive Services of the MoH

1.2. Integrated Management of Childhood Illness

Integrated Management of Childhood Illness is a strategy which contributes to the reduction of mortality and morbidity associated with the major causes of childhood illness (pneumonia, malaria, diarrhoea, measles and malnutrition). Its development by WHO and UNICEF started in 1992.

IMCI has 3 major components:

1. Improving case management skills of health workers through provision of guidelines on IMCI by training in standardized procedures for first level health facilities and follow-up of trained health workers.
2. Improving health system by:
   * ensuring availability of essential drugs and other supplies
   * improving organisation of work at the health facility level
   * improving monitoring and supervision
   * strengthening the referral system and referral care
3. Improving family and community practices through education of mothers, fathers, other child care takers with focus on:
   * health seeking behaviour
   * compliance with prescribed treatment
   * care at home
   * overall health promotion

Implementation of IMCI occurs in 3 phases, namely:

1. Introduction
2. Early implementation
3. Expansion

1.3. IMCI in Tanzania

Tanzania has gone through introduction and early implementation phases, which consisted of introduction to the country, orientation, adaptation including translation into Kiswahili and printing of the materials, in-service training including follow-up after 4-6 weeks, preservice training, improvement of health systems including drug availability and supervision, and review and planning for expansion.

1.4. Achievements

So far Tanzania has been focusing on the first component, with some activities in the second component. Since 1996, the materials have been adapted to the local policy and treatment guidelines, translated and printed, with the help of other programmes, including: Malaria, EPI, TFNC, MUCHS, Health Education, MCH, PHC, and partners.

In the last 2 years about 65 facilitators have been trained. Nine training sites have been developed. 355 health workers (mainly paediatricians, Medical Officers, Assistant Medical Officers, Clinical Officers and Clinical Assistants) have been trained from 7 districts (almost covering 50% of clinically trained health workers in each facility from 6 of these districts). 166 (69.5%) out of 255 eligible for follow-up have been visited once, and 46 of these (28%) have been visited twice. Results of follow-up visits have shown that health workers were able to implement the IMCI skills. Caretakers expressed satisfaction with the improved care. The DHMTs of 3 of these districts have included IMCI in their district health plans, and initiated changes to support health workers to use IMCI approach, by making IMCI recommended drugs available that are not in the monthly drug kits.

IMCI implementation in the 7 districts has been achieved through close collaboration between MoH and 5 partners, each assisting 1 or 2 districts: WHO (Mpwapwa), Tanzania Essential Health Interventions Project (Morogoro rural, Rufiji), UNICEF (Magu), GTZ (Korogwe, Muheza) and World Bank Community Health fund Project (Igunga).

Furthermore IMCI was introduced as a block course within the paediatric rotation of 2 paramedical schools: the AMO training school in Mbeya and the Clinical Officers school in Kibaha. The purpose is to explore ways of sustaining IMCI. In Mbeya 30 students have been trained and in Kibaha 9 students in the first block course. Tanzania is the first country in the world to introduce IMCI in the preservice institutions.

One international course for 23 participants from English speaking African countries took place in Arusha in 1997.

Aspects of the community component were incorporated into the training of health workers to improve home care and breast feeding practices, through counselling, using the adapted mothers card.

1.5. RATIONALE FOR THE STRATEGY

Following a review of early implementation of IMCI in Tanzania, a five year strategy document was developed to guide the Ministry of Health and her partners in the implementation of IMCI. This document provides a vision of IMCI in both the expansion phase and for implementation in new districts.

2. GOAL AND GENERAL OBJECTIVE

The overall **goal** of IMCI strategy is to contribute to the reduction in childhood mortality in children under five years of age.

The **general objective** is to improve the quality of care provided to children under 5 years, at home and at the health facility, through

* improvement of skills of health workers
* improvement of health services
* improvement of family and community practices.

3. SPECIFIC OBJECTIVES

3.1. Organisation and management of IMCI: *Central, regional and district*

1. To strengthen central level capacity to facilitate implementation of the IMCI strategy in Tanzania

2. To adapt the IMCI guidelines to be consistent with national policies of IMCI related programmes.

3. To strengthen regional capacity to support districts to introduce and sustain IMCI activities

4. To obtain consensus and commitment on IMCI among the stakeholders in the districts.

5. To ensure the quality of IMCI implementation at the district.

3.2. Training including follow-up.

6. To strengthen skills of health workers in managing children under 5 years of age, through training, including follow-up after 4-6 weeks of the course.

7. To achieve the inclusion of IMCI skills in undergraduate or basic training of all medical and allied health staff and registered nurses schools.

3.3. Strengthening health systems

Drugs

8. To ensure that all IMCI recommended drugs are available in adequate quantities at dispensaries and health centres, at all times.

9. To ensure rational use of drugs.

Referral

10. To achieve at least 60% success rate for the referral of severely ill children, where referral is possible.

11. To improve accessibility to functional referral centres.

12. To improve the quality of care of severely ill children where referral is not possible.

13. To reduce the proportion of severely ill children dying at home.

Supervision and monitoring

14. To strengthen central capacity to monitor and evaluate progress of IMCI

implementation, utilizing the results to generate support.

15. To ensure that all IMCI-trained health workers receive proper and regular supervision through routine supervision visits.

3.4. Family and community practices.

16. To establish a framework for development, planning and coordination of family and community IMCI.

4. STRATEGIES AND ACTIVITIES

4.1. ORGANIZATION AND MANAGEMENT - CENTRAL, REGIONAL AND DISTRICT LEVEL

Background

Integrated Management of Childhood Illness (IMCI) is a strategy that cuts across different ministries and different programmes within the Ministry of Health. To achieve the overall goals and objectives, a multi-sectoral approach is mandatory. The Ministry of Health will implement IMCI as a collaborative effort between its different departments and will involve other key ministries and partners. The central level will work closely with regions and districts in policy setting and implementation.

Objective 1: To strengthen central level capacity to facilitate implementation of the IMCI strategy in Tanzania

Strategy 1: Institutionalizing IMCI within the existing structure of the Ministry of Health

Activities. The Ministry of Health will

- Appoint an IMCI coordinator

- Identify a placement of IMCI within the existing structure of the Ministry of Health. A proposed home might be the Reproductive and Child Health unit. The child health component of ARI and CDD activities will be moved to the child health section.

- Strengthen the capacity of the respective unit to act as an IMCI secretariat and take on the added responsibilities of IMCI coordination. The IMCI secretariat should be equipped with working tools such as a computer and stationery.

Strategy 2: Sensitizing further, key decision-makers and relevant programme staff within the Ministry of Health and other partners about the benefits and implications of the IMCI strategy

Activities. The IMCI working group will:

. Conduct an orientation meeting for senior officials in the Ministry of Health, representatives of relevant programmes and units within the MoH and other ministries, Key Regional Health Personnel, and interested partners.

. Share information about IMCI on a regular basis with all interested parties.

. Conduct periodic meetings to update decision-makers in the Ministry of Health and partners about progress of IMCI implementation and issues at stake.

Strategy 3: Strengthening collaboration and coordination of relevant units within the Ministry of Health and partners (multi- and bilateral agencies, NGOs).

Activities. The Ministry of Health will

- Form an IMCI working group under the leadership of the Director of Preventive Services Department involving all relevant units within the Ministry of Health and related ministries, and partners.

    - The proposed membership would include representatives from Ministry of Health Child Health Secretariat (including IMCI, CDD, ARI), EPI, Malaria, TFNC, PSU, PHC, HMIS, HEU, HMIS Epidemiology, Directorate of Training, Ministry of Community Development, Women and Children (MOCDWC), Planning Commission, Prime Minister's Office (Local Government), Ministry of Education, Ministry of Agriculture (Nutrition unit), Social Welfare department, collaborating partners like UNICEF, WHO, TEHIP, GTZ, World Bank, DANIDA; NGOs like CARE, CSSC; professional associations like Paediatric Association of Tanzania (PAT), Association for Private Hospitals in Tanzania (APHTA), Christian Medical Association of Tanzania, DMOS working in 1 or 2 selected districts for community component, training institutions such as MUCHS, AMOS, Cos and Nursing Schools.

- Develop terms of reference for the working group which will include advocacy, advice, policy formulation, planning, coordination, monitoring and evaluation of IMCI activities.

- The working group will be divided into three subgroups namely: adaptation (of IMCI guidelines), implementation (to improve the skills of health workers and health system), and family and community practices.

- The subgroups will meet at least quarterly and more frequently as needed.

Strategy 4: Strengthening central capacity to support regions and districts to introduce and sustain IMCI activities

Activities. The Ministry of Health will:

- Coordinate the training of a pool of well-qualified course directors, clinical instructors, facilitators and supervisors, including staff from the different programmes who are part of the working group.

- Support districts which are piloting health sector reforms in the introduction of IMCI and carefully document the experiences in order to assess the specific needs for technical input.

- Coordinate planning of specific programme activities that are relevant to IMCI in those districts targeted for implementation. Examples include ensuring drug availability, cold chain maintenance, micronutrient supplementation, promotion of Insecticide Treated Bednets (ITN) and breastfeeding counselling courses.

- Mobilize financial resources for IMCI implementation from within the government,

donors and NGOs.

Strategy 5: Improving IMCI implementation through operational research and documentation

The IMCI working group will

- Identify relevant research areas for IMCI implementation based on the documentation and monitoring of implementation.

- Collaborate and coordinate with research institutions and partners to initiate and conduct research.

- Disseminate results and use them to make specific adjustments in the IMCI strategy.

Objective 2: To adapt the IMCI guidelines to be consistent with national policies of IMCI related programmes.

Strategy 1: Consultation with IMCI related programmes to reach a consensus on national programme specific policies.

Activities.
The adaptation working subgroup will:

- Identify issues needing adaptation, including the annex 'Where referral is not possible' and include it in the main course.

- Harmonize different policies and treatment guidelines (EPI, TFNC, PSU, HMIS, malaria).

Objective 3: To strengthen regional capacity to support districts to introduce and sustain IMCI activities

Strategy 1: Orienting and training the Regional Secretariat and partners on the IMCI strategy

Activities. The IMCI working group will

- Conduct orientation meetings for Regional Secretariats, and relevant partners working at that level.

- Facilitate the training of selected members of RHMT in IMCI clinical course and follow-up skills.

- Build a pool of regional staff, through on-the-job training, to support selected districts to conduct orientation and planning meetings.

Strategy 2: Involving RHMT members in planning, supervision and monitoring of IMCI

activities at district level.

Activities. The IMCI working group will

- Provide regions with clear criteria for selecting districts ready for IMCI implementation. Proposed criteria include

- willingness of district authorities to implement IMCI, shown by inclusion of IMCI n comprehensive district plans and district health plans.

- district capacity to implement IMCI, shown by the presence of staff who can be trained as trainers and supervisors, and members of the DHMT who have undergone managerial training on health systems.

- availability of funds (from the local government, central government, and/or interested partners).

- high infant and under-five mortality rate.

- Conduct regular coordination meetings with the regional level.

- Conduct joint support supervision to districts with regional level during the early phase of IMCI implementation.

Objective 4. To obtain consensus and commitment on IMCI among the stakeholders in the districts.

Strategy 1: Promoting intensive advocacy and social mobilization at different levels in the district.

Activities:

- Conduct preliminary visits to districts by central and/or regional level.

- Support districts to conduct orientation meetings for district authorities including councillors, community representatives and interested partners.

- Conduct sensitization meeting with management of training sites.

Objective 5
To ensure the quality of IMCI implementation at the district.

Strategy 1: Strengthening of district capacity for IMCI implementation.

Activities

- Support the districts to develop comprehensive district health plans including IMCI

Activities

- Identify district IMCI training sites using standard selection criteria

- Train health workers in HMIS
- Train DHMTs in health management and administration of resources.
- Promote District trainers to Course Directors and Clinical Instructors through structured apprenticeship.
- Incorporate IMCI training in the ongoing continuing education activities.

Strategy 2: Strengthening of health facility support for IMCI in the district.

Activities.

- Encourage DHMTs and communities to mobilize local resources to rehabilitate health facilities to make them suitable sites for health service delivery.

- Redeploy clinicians equally over health facilities.

Strategy 3: Promotion of breastfeeding in districts.

Activities
- Train health workers in the BFHI strategy and breastfeeding counselling course.
- Support health workers to appropriately counsel mothers on breastfeeding.
- Assess health facilities for Baby Friendliness.

Strategy 4: Extension of IMCI activities beyond the health facility.

Activities
- Strengthen multi-sectoral coordination mechanism at all levels in the district.
- Ensure participatory planning and budgeting and resource mobilisation.

4.2. TRAINING INCLUDING FOLLOW-UP

Expansion of in-service training.

The following issues were considered when deciding on the pace of expansion of training.

1. Training including follow-up has been the main activity in IMCI up to now. Those trained found IMCI very useful, and this justifies expansion.
2. The expansion is limited by the small number of suitable Course Directors and Clinical Instructors (MO or maybe AMOs), and the number of facilitators that can be trained.
3. Training should only be conducted when at least one follow-up visit can be guaranteed, as has been successfully done in most districts during the early implementation phase.
4. Although it is desirable to try to expand training quickly to as many new districts as possible, it is believed that other components, such as regular supervision and availability of drugs, should be in place before the expansion of training can be accelerated.

Considering these 4 issues, the pace of expansion of training should be carefully executed. A possible target is to train health workers treating children in half the districts of the country.

* within 7 early implementing districts 100% of health workers.
* in new districts, 50% of health workers in each health facility.

It is unlikely to achieve nation wide coverage of training on IMCI within 5 years.

Introduction of IMCI into preservice training

Pre-service training is a potentially sustainable way of introducing IMCI clinical skills and knowledge. In addition it is a way of accelerating the coverage of IMCI training in the country.

In preservice training IMCI is learned as a part of the basic skills, and therefore the impact on clinical behaviour is potentially greater than that achieved with in-service training.

The skills will be learned by all potential health workers, private as well as the public sectors.

The inclusion of IMCI in the training schedules and curricula will increase its visibility and acceptability in academic and training circles.

Objective 6. To strengthen skills of health workers in managing children under 5 years of age through training including follow-up 4-6 weeks after the course.

Strategy 1. Capacity building for training at central, regional and district levels.

Activities:

- Identify and train at least 2-3 Course Directors and Clinical Instructors per region (upgrade current facilitators and train new ones).

- Identify and train 6 potential trainers per district.

- Include 3 or more DHMT members (DMO, DMCHco, DHO).

- Identify or develop 1 training site within the district to reduce the cost of training. Consider Zonal Continuing Education Centres, and Institute of Continuing Education, MUCHS.

- Develop or strengthen 3 national training sites (Arusha, Morogoro, paediatrics department MUCHS).

- Train facilitators from IMCI related programmes such as TFNC, malaria, EPI, HEU, RCHU.

- Train all paediatricians as facilitators.

- Training of all Course Directors & Clinical Instructors as supervision master trainers.

- Training of 6 facilitators per district in follow-up skills.

- Produce enough training materials, including laminated mothers' cards.

Strategy 2. Capacity building for managing sick children under 5 years.

Activities:

- Train health workers managing children under 5 years.

- Conduct initial follow-up visits to all trained health workers after 4-6 weeks of the course.

- Explore options for training health workers with low reading skills, who are managing sick children at dispensaries, such as nurse assistants.

Strategy 3. Incorporation of IMCI in various existing medical Continuing Medical Education Programmes in hospitals.

Activities:

- Provide hospitals with materials

- Hold 2 times per year sensitization and refresher seminars at hospitals

- Include IMCI course in curricula of continuing education.

Objective 7. To achieve inclusion of IMCI in undergraduate or basic training of all medical and allied health staff and registered nurses.

Strategy 1. Introduction of IMCI training into individual medical and allied health training and registered nurses schools without modifying the present curricula.

This is both a preliminary to the development of the curricula and a way of starting training

without delay. It will involve:

- The development of options for the use of IMCI training materials
- Detailed planning and preparation for the introduction into each school
- Development of modalities for giving technical support to the schools at all stages.

It is anticipated that at least half of the schools will be able to introduce IMCI into the training before the curricula are modified.

Activities

- Conduct workshop to develop options for use of IMCI course materials in pre-service training, drawing on experience of Mbeya and Kibaha.

- Train Principals of schools and senior staff from the Training Department, including the Head of Nursing Education

- Hold consultation on introduction of pre-service training.

- Select schools, giving priority to AMO and Clinical Officers schools.

- Train tutors in facilitation skills.

- Plan for individual schools - one session in each year, including issues related to sustainability.

- Provide video equipment and other teaching materials to schools undertaking training.

- Train staff of the health facilities serving as practice areas for training institutions.

- Train students on IMCI in selected schools, including Mbeya and Kibaha.

- Supervise and monitor IMCI training in schools from Central level, including monitoring.

- Evaluate experience with introduction of IMCI in pre-service.

Strategy 2. *Modification of the curricula for undergraduate and basic training for medical, allied health and nursing staff.*

The long-term development of IMCI pre-service training will require curriculum change. Modifications will be proposed at the time of the next regular review, drawing on the experience of the work in schools prior to the revision. Needs for updating will be reviewed during each curriculum review thereafter.

Activities

- Organise workshop to review current AMO, Clinical Officer and Nurse curricula with regard to IMCI and make proposals for reform (using data from evaluation of preservice experience)

- Develop new curricula as part of scheduled revision.

- Print and distribute revised curricula.

Activity Targets:

- 1 AMO school and CO school in 1998, and 1 AMO and 3 CO schools (two upgrading programme and one 3-year programme) in 1999.

- By the end of five years all AMO and Clinical Officers schools will have introduced suitable IMCI training.

- By the end of 2001 IMCI case management training will have been introduced into the training in the Medical School.

- By the end of five years the curricula for Medical students, Assistant Medical Officers, Clinical Officers and Nurses will have been revised to include suitable IMCI training.

4.3. HEALTH SYSTEMS STRENGTHENING

A Ensuring Drug Availability

Background

One factor influencing the success of IMCI as a strategy is the availability of IMCI recommended drugs. The current NEDLIST allows for the supply of all first line drugs via the EDP kit, but the amount supplied is not adequate and collected data suggests only 80% availability. The current major constraint to IMCI is the non-availability of 2nd line and pre-referral recommended drugs which are not on the NEDLIST for supply to health centres and dispensaries.

Objectives 8. To ensure that all IMCI recommended drugs are available in adequate quantities at dispensaries and health centres, at all times.

Strategies 1. Improvement of policy support for IMCI recommended drugs.

This involves consultations with the relevant bodies to ensure the availability of drugs at all levels of health care delivery. Consultations will include the National Essential Drug List of Tanzania Committee, Prime Ministers' Office and other interested parties.

Activities:

- Conduct an orientation meeting for policy and decision makers at the Ministry of Health (link with paragraph 4.1).

- Collect information on the need, effectiveness and use of IMCI recommended drugs from dispensaries and health centres.

- Organise meetings with the NEDLIST Committee to discuss the information collected.

Strategy 2. Strengthening drug procurement and distribution systems.

The existing Essential Drugs Kit system ensures the availability of first line drugs to about 80% of dispensaries and health centres. The Ministry of Health is planning to introduce an indent system for drug procurement. Successful implementation of the indent system will improve drug supply to the dispensaries and health centres. Drug Capitalization Programme currently being pilot-tested at hospital level aims at providing health facilities with a revolving fund to ensure a constant supply of drugs. The ongoing Health Sector Reforms aim at introducing other mechanisms for cost-sharing through Community Health Funding and Health Insurance. District Health Boards and Hospital Boards will be empowered to look for alternative sources of funding and will supervise the proper utilization of the funds. The private sector will be developed to complement the public sector in the provision of health services.

Activities

- Implement the indent system.
- Increase the quantity of IMCI recommended drugs in the EDP kit to meet estimated or actual needs.
- Prioritize and budget for drug supplies in the district health plans.

Objective 9. To achieve rational use of drugs at all levels.

Strategy 3. Strengthening rational drug use.

The standard training on IMCI includes a focus on rational drug in the management of the sick child. These efforts will be complemented with the Standard Treatment Guidelines produced by the Ministry of Health to guide health workers on proper prescribing.

Activities

- Train health facility workers on IMCI emphasising rational drug use.
- Supervise IMCI trained workers in drug use and the management of supplies.

B Strengthening Referral Pathways

Background

The referral care of children has proved to be inadequate in most places implementing IMCI. The problems include reduced confidence in the quality of care at the referral centres, difficulties in transport and physical access, and financial and social constraints faced by caretakers. The overall solution to the problem will require inputs from different sectors and is unlikely to be achieved in a short time.

Objective 10. To achieve at least 60% success rate for the referral of severely ill children, where referral is possible.

Strategy 1. Improving the counselling skills of health workers.

Improvement of counselling skills of the health workers involves training and proper supervision. The standard IMCI training on Case management has counselling of caretakers to accept referral as a major part. The IMCI initial follow-up visit aims at reinforcing the skills obtained during the training. Complementing the IMCI efforts is the Health Sector Reforms support to districts which aims at increasing the capacity of the districts to conduct routine supervision visits. The country=s six zones[1] have each a Zonal Continuing Education Centre, which have a potential to conduct in service training of health workers on counselling skills.

[1] Lake zone, Southern highland zone, Central zone, Northern highland zone, Southern zone, Eastern zone.

Activities

- Train health workers on IMCI in the area of counselling and emphasising practical support to the caretaker taking the child for referral care.

Strategy 2. Improving the quality of care at referral facilities.

Good quality care depends on the improvement of kills of personnel and adequate supplies so as to instill confidence in caretakers to agree to referral. District Health Boards and Hospital Boards to be formed in line with Health Sector Reforms will be empowered to mobilize funds from various sources and control its use. Drug capitalization programmes apart from ensuring constant availability of drugs in hospitals will also have a training component for the health workers on rational drug use, drug management and financial control.

Activities

-

Make available to clinical staff at referral care facilities guidelines for the management of the referred child.

- Implement FAMS training in the context of health sector reforms.

- Train and supervise health workers at referral centres in the management of the sick child.

Strategy 3. Facilitating the transfer of children who need referral.

There is a need for multisectoral efforts that will involve the community in improving public transport system. Communities can organise themselves to provide transport for patients requiring referral, including children. These efforts will be complemented by the Safe Motherhood Initiative which also seeks to improve transport system to referral centres. In some districts (Mtwara Rural) the district authority has installed a radio call network in the remote health facilities to facilitate communication to the centres where transport is available.

Activity

- Mobilise the community to facilitate transport for persons needing referral including children.

Objective 11. To improve accessibility to functional referral centres.

Strategy 1. Increasing the number of health centres serving as referral centres for the dispensaries as was intended.

For the health centres to function as referral centres for dispensaries there needs to be personnel with adequate skills and adequate supplies. There is currently a sufficient number of health centres in the country manned by appropriate and most often adequate staff. However, shortages of equipment and supplies reduce the role of these centres to primary level care similar to dispensaries. Financial and organizational reforms taking place in the health sector will upgrade health centres to function as referral sites for dispensaries.

Activity

- Provide equipment and supplies to health centres so that they can function as referral centres.

Objective 12. To improve the quality of care of severely ill children where referral is not possible.

Strategy 1. Improving the capacity of health workers to manage severely ill children where referral is not possible.

Proper management of severely ill children will involve improvement of personnel skills and adequate supplies. In addition, policy support is necessary to allow the use of all the IMCI recommended drugs at the dispensary level. The Standard Treatment Guidelines has at present addressed some, though not all, of the IMCI recommendations such as the treatment of pneumonia where referral is not possible.

Activities

- See section on adaption.

Objective 13. To reduce the proportion of severely ill children dying at home.

Strategy 1. Improving the capacity of caretakers to identify the early signs of illness and seek appropriate care promptly.

Various modalities will be used to educate parents on identification of early signs of illness and the importance of seeking appropriate care promptly. At the moment, health education sessions are being conducted at the MCH clinics and some OPD clinics. More than 80 per cent of mothers attend MCH clinic during pregnancy at least once thus creating a good forum for transmitting IMCI messages.

Activities

- Print IMCI mother's card in large quantities.
- Make the IMCI mother's card available to caretakers.
- Include care seeking behaviour and danger signs in Health Education sessions in the MCH clinic.

Objective 13: Strengthening central capacity to document, monitor and evaluate progress of IMCI implementation, and utilizing the results to generate support.

Strategy 1. Incorporation of IMCI clinical classification, referral information and monitoring indicators into the HMIS

The IMCI working group will define, in collaboration with districts, the information to be monitored at different levels (including training coverage, quality of training, results from follow-up and routine supervision).

Activity

- Organise meetings of the IMCI working group to discuss IMCI information needs.

Objective 14. To ensure that all IMCI trained workers receive proper and regular supervision through routine supervision needs.

Strategy 1. The inclusion of one IMCI trained supervisor in routine supervision.

Build central, regional and district capacity for monitoring IMCI implementation by providing specific tools and guidance on their use. The tools will include user-friendly IMCI checklists and monitoring forms for initial follow-up visits, and an adapted (shortened) version to be used during routine supervision.

IMCI training provides for training of supervisors. The organisational structure at district level allows the cooption of technical personnel as members of the DHMT. Health Sector Support on supervision at district level will facilitate the cooption of an IMCI trained supervisor during routine supervision visits.

Activities

- IMCI working group to advocate for the co-option of clinical supervisors into the DHMT.

- Identify and train clinical supervisors.

- Maintain and update after every training, an inventory of:
  * all health facilities & staff in district
  * Proportion of IMCI trained health workers
  * follow-up visits & results
  * costs of all IMCI related activities

Strategy 2. Development and inclusion of IMCI checklist into the routine supervision checklist.

Achievement of this objective involves review of the current IMCI checklist before integrating it into the routine checklist. The development of the National Supervision Guidelines will facilitate the inclusion of the IMCI checklist for routine supervision.

Improvement of organization at work involves IMCI trained health workers passing over skills to other staff at the health facilities. IMCI follow-up and the routine supervision will further consolidate the skills imparted by the IMCI trained health workers. DHMT capacity building efforts by the Ministry of health will enhance the capacity of DHMT members to perform routine supervision more effectively.

Activities

- Adapt the routine supervision checklist to incorporate needs, including the organisation of work.

4.4. IMPROVEMENT OF FAMILY AND COMMUNITY PRACTICES

Rationale

Tanzania has a high infant and under five mortality of 88/1000 and 137/1000 respectively. Over 70 per cent of these deaths are due to diarrhoea, ARI, malaria, measles with malnutrition as an underlying cause.

The IMCI strategy has been developed to contribute to the reduction of the high under five morbidity and mortality. The improvement of family and community practices is an important element in achieving this objective. Although there is inadequate information on home care and care seeking practices, there is evidence that in Tanzania, as well as other developing countries, poor family and community practices in child care and care seeking is among factors contributing to the high childhood morbidity and mortality.

In Tanzania there are many existing community based programmes e.g., the Child Survival, Protection and Development Programme (CSPD) implemented in 54 districts; Health Sanitation and Water (HESAWA); School Programmes; and the Community Based Health Care Programme (CBHC) for training community health workers. These programme provide an opportunity for implementing community IMCI. There is need, however, to further strengthen the household and community capacity in child home care and care seeking behaviours.

General objectives:

The development and implementation of component three of IMCI should address the following long term objectives:

* To strengthen and support family and community actions to prevent young child morbidity and mortality

* To contribute to improving child growth and development

Objective 16. **To establish a framework for development, planning and coordination of family and community IMCI.**

Strategies

Strategy 1: *Establishing a sub-working group on family and community IMCI with the following specific terms of reference:*

Collect and review existing information and data regarding home care and care seeking behaviour as well as aspects of child growth and development.

Identify one or two districts from those already implementing IMCI for:-

a. detailed information gathering
b. making an inventory of ongoing community-oriented activities and materials
c. early implementation and testing of approaches

Make an inventory of existing tools for community entry processes. Review the tools for potential use in community IMCI and adapt if necessary. Facilitate the development of additional tools if necessary.

Review existing messages developed by different programmes which aim at improving family and community practices with regard to home care and care seeking of childhood illnesses, child growth and development, and adapt them to be consistent with IMCI as necessary.

Facilitate the development of community IMCI objectives and implementation strategy at all levels which includes

a. Joint integrated planning with the community
b. Facilitating training of resource people
c. Facilitating training of communication skills of community extension workers
d. Orientation of extension workers on a holistic approach to community child care.

Develop indicators for monitoring progress with technical support from UNICEF and WHO.

It is proposed that the working group on community IMCI should include representatives from:

- Prime Ministers Office (Local Government).
- Ministry of Community Development, Women and Children.
- Ministry of Education.
- Ministry of Agriculture (Nutrition Unit).
- Tanzania Food and Nutrition Centre.
- Ministry of Health (Malaria Control Programme IMCI, Environmental Health and Sanitation, Epidemiology Unit), Reproductive Health.
- Social welfare department.
- UNICEF, WHO, NGOs and DMOs working in the proposed districts.
- Social Scientist
- Public Health Specialist.

Activities:

- Debrief the MoH officials and other partners on IMCI, with particular emphasis on family and community practices, using the Morogoro report and the Tanga Review report.
- Identify the members of the working sub group on family and community practices.
- Convene meeting of working sub group on family and community practices for orientation, review of terms of reference and preparation of work plan.

Strategy 2: Utilizing existing structures and opportunities within programmes, such as CDD/ARI, MCH Services, Nutrition Programmes and CSPD to establish entry processes into the community.

Activities:

- Make an inventory of existing structures, community based programmes and supporting institutions and organisations.
- Review and utilize opportunities in the existing community based programmes.
- Review mothers card, adapt and produce for community use.
- Orient health workers on principles and strategies of community IMCI

5. MONITORING AND EVALUATION

The IMCI coordinator with support from the IMCI working group and partners will develop mechanisms and indicators to document and monitor progress of IMCI implementation in the country. IMCI should benefit from the existing monitoring and evaluation mechanisms, such as HMIS and regular supervision reports.

The working group will organize annual reviews to assess progress, strengths and weaknesses. Participants in the review will include the IMCI working group, partners and representatives from districts and regions involved in IMCI implementation. The findings will be utilized to guide the planning for the following year.

Eleven appropriate indicators for in-service training and availability of drugs have been developed. They need to be reviewed, considering indicators from other IMCI related programmes.

Based on current experience possible indicators are:

a. For preservice
* Time allocated to teaching on IMCI and IMCI related subjects.
* Proportion of IMCI content covered
* Adequacy of clinical practice
* Availability of appropriate training materials

b. For drug availability
* Milestone: Having all drugs recommended by IMCI in NEDLIST up to dispensary level.
* Proportion of time of stock-out of IMCI recommended drugs in HMIS reports

c. For referral
* Proportion of caretakers accepting referral.
* Proportion of referrals reaching the referral centre.
* Number of health centres functioning as referral sites.

An external mid-term evaluation of IMCI implementation in Tanzania will be conducted with partners at the end of the two-year plan of action. At the end of the five years another external evaluation will be conducted.

The following methods can be considered for evaluation:
- Health Facility survey
- Data from follow-up and supervision.
- Training site survey:
  * quality of patient care
  * quality of facility support
  * assess attitudes of health workers in regard to IMCI

Tools will be developed for the evaluation.

Training materials

* fac. guides for each facilitator
* 1 set of videos per district
* 25 photograph booklets/region
* 1 set of wallcharts per district
* laminated mothers card