IMCI integrated management of childhood illness

I - M - C - I

household and community component

A Resource Manual on Strategies and Implementation Steps

Health Section
Eastern and Southern African
Regional Office

The Household and Community Component of IMCI: A Resource Manual on Strategies and Implementation Steps

Prepared by

Health Section,
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The content of this Resource Manual is based on:

- Country experiences and lessons learned in the process of implementing components one and two of IMCI.

- Discussions at the sub-regional workshop to share experiences in the development and implementation of the household and community component of IMCI in the Eastern and Southern African Region (ESAR), held on 23 – 26 March 1999, Nairobi, Kenya, organised by the Health Section of UNICEF Regional Office.

The purpose of this resource manual is to assist countries to develop and implement the household and community component of IMCI. The manual is intended to be an operational tool for adaptation to each country's local situation. It should be used in conjunction with other guidelines developed by WHO and UNICEF on the implementation of IMCI.

The content of this manual does not necessarily reflect the policies or views of UNICEF.

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Abbreviations

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ARI	acute respiratory infection
BASICS	Basic Support for Institutionalising Child Survival
BCG	Bacille Calmette-Guerin (TB vaccination)
CBO	community-based organisation
CDC	Centre for Disease Control
CDD	control of diarrhoeal diseases
CHW	community health worker
CORE	The Child Survival Collaboration and Resources
CORP	community-owned resource person
CSGD	child survival, growth, and development
DFID	Department for International Development
DHMT	District Health Management Team
DPT	diphtheria, pertussis and tetanus
EPI	expanded programme on immunisation
ESAR	Eastern and Southern African Region
ESARO	Eastern and Southern African Regional Office
Hb	Hepatitis B
HH/C IMCI	Household and Community Component of IMCI
HIV	human immunodeficiency virus
IEC	information, education, and communication
IMCI	integrated management of childhood illness
ITN	insecticide-treated net
MOH	ministry of health
NGO	non-governmental organisation
OPV	oral polio vaccine
PHC	primary health care
PLA	participatory learning and action
PRA	participatory rural appraisal
PVO	private voluntary organisation
TBA	traditional birth attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO/AFRO	World Health Organisation, Africa Regional Office

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Introduction

Five leading causes of death for children under 5 years of age

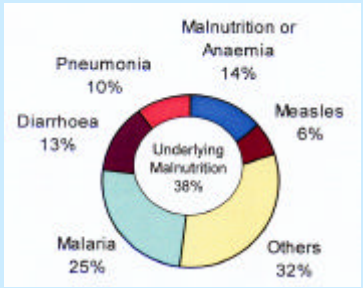
1. Acute Respiratory Infections
2. Diarrhoea
3. Malaria
4. Measles
5. Malnutrition

Other factors contributing to high morbidity and mortality

- Poor quality of health services
- Poverty
- Ignorance
- Poor access to health services
- Low utilisation of health services
- HIV/AIDS

Despite substantial efforts to improve the health and nutritional status of children in developing countries in the last two decades, every year about 12 million children die before they reach their fifth birthday, many during the first year of life. The majority of these deaths occur in the African region. Most countries in Africa continue to register high infant mortality rates (IMR) ranging from 50/1000 to 191/1000 and under-five mortality rates (U5MR) ranging from 100/1000 to 320/1000 (*The State of the World's Children 1999*). Approximately 70% of these deaths are due to only five conditions - acute respiratory infections, diarrhoea, malaria, measles and malnutrition - or a combination of these conditions. Malnutrition is an underlying factor in about 54% of the deaths.

Causes of under-five mortality, Uganda, 1994



These five conditions are responsible for about 83% of outpatient consultations. Malaria alone is responsible for 1.5-2.7 million deaths per year, 90% of them in Africa. Every day, 1,300 to 2,100 African children die of malaria. In the Eastern and Southern Africa Region (ESAR) it is estimated that 25-60 % of visits to health facilities are due to malaria. HIV/AIDS is also having a devastating effect on child survival, growth, and development, particularly in ESAR. In this region, HIV/AIDS is projected to be responsible for 20-64% of under-five child mortality by the year 2005, reversing recent gains in infant and child mortality rates.

Other factors contributing to high morbidity and mortality of children in African countries are poor quality of health services, poverty, ignorance, poor access, and low utilisation of services. Available information from some countries in ESAR indicates that 40-80% of all child deaths occur in the home without the child receiving any care from a trained health worker or attending a health facility. For example, in Tanzania more than 160,000 children under five years of age die annually. About 80% of these deaths occur at home and 46% of them die without prior contact with the health facilities. It is important to note that 72% of these deaths are preventable or curable by using existing low cost technologies.

Lessons have been learned during the implementation of disease-specific vertical programmes, such as Control of Diarrhoea Diseases (CDD), Acute Respiratory Infections (ARI) and Expanded Programme on Immunisations (EPI), under the umbrella of primary health care (PHC). First, integrated and holistic approaches to childcare are needed and second, the need for community involvement has become evident. In most cases, the benefits of holistic and integrated approaches, multi-sectoral collaboration, strategic partnerships, and community participation have not been fully maximised in planning and implementing community based programmes. Success in reducing childhood mortality and morbidity requires more than making available adequate health services and well trained health personnel.

In addition, most sick children present with signs and symptoms related to more than one disease entity. This overlap means that a single diagnosis may not be appropriate, and treatment may be complicated by the need to combine therapy for several conditions. An integrated approach to managing sick children is therefore indicated, as is the need for child health programmes to go beyond single diseases and address the overall health of a child. Furthermore, experience has shown an important link between women's health, maternal well-being, and children's health. In response to some of the above-cited concerns, WHO in collaboration with UNICEF developed the Integrated Management of Childhood Illness (IMCI) strategy.

Integrated Management of Childhood Illness (IMCI)

IMCI is a broad strategy with an overall objective of contributing to reducing child morbidity and mortality in developing countries. It encompasses a range of interventions to prevent illness and reduce deaths from common childhood conditions, and to promote child health and development. The strategy combines improved management of common childhood illnesses with aspects of nutrition, immunisation, and other important factors influencing child health, including maternal health.

Three components of IMCI

Improve health worker skills

Improve the health system to deliver IMCI

Improve family and community practices

The IMCI strategy involves the following three components:

- Improvements in the case management skills of health workers through training, support supervision and provision of locally adapted guidelines on Integrated Management of Childhood Illness and activities to promote their use.
- Improvements in the health systems required to deliver quality care.
- Improvements in the household and community practices for child survival, growth, and development.

The Household and Community Component of IMCI

Although households and communities have a major responsibility to provide care to their children, in most cases they have not been effectively involved or consulted in the development and implementation of programmes meant to address issues related to their children's health, nutrition, growth, and development. Success in reducing childhood morbidity and mortality requires active and meaningful participation by communities, and partnership between health workers and households with support from their communities. Households and communities need to be empowered with knowledge and skills regarding child health and development. In addition to an enabling environment, in the form of responsive health system and policies, communities need to be mobilised and motivated.

The household and community component of IMCI (HH/C IMCI) seeks to initiate, reinforce and sustain household practices that are important for child survival, growth, and development within the overall framework of community capacity development.

Although the implementation of components one and two of IMCI started in 1995, the development of component three started only after the Santa Domingo meeting. At the first global review and co-ordination meeting on IMCI held at Santo Domingo, the Dominican Republic, in September 1997, it was recognised that improving the quality of care for sick children at the health facility level alone would have a limited impact on reducing child morbidity and mortality. The need to develop a household and community based approach to promote household practices that are key to child survival, growth, and development was emphasised. At this meeting, UNICEF was given the mandate to take the lead in the development of the household and community component of IMCI.

Through a number of inter-agency (UNICEF, WHO, World Bank, USAID, DFID, BASICS and PVOs/NGOs including CORE) consultations and regional meetings, a common understanding of HH/C IMCI and consensus on the desired household practices to promote child survival, growth, and development have been reached. Globally, 12 key household practices have been identified and agreed upon by major partners. The Eastern and Southern African Region (ESAR), has identified four additional household practices towards prevention of HIV/AIDS, prevention of child abuse and accidents, and participation of fathers in care for children. These practices are generic and are to be adapted according to the local situation and priorities at country, district and community levels.

0perational definition and objectives

For operational purposes, the household and community component of IMCI is defined as an integrated child care approach that aims at improving key household practices that are likely to have the greatest

impact on child survival, growth, and development. The specific objectives are to

- Prevent common childhood illness including malnutrition, injuries, child abuse, and neglect at the household and community level.
- Improve the household and community response to childhood illness and the quality of care provided at home.
- Improve appropriate and timely care seeking behaviour when children need additional assistance outside the home.
- Increase compliance to recommended treatment and advice from trained care providers.
- Promote a supportive and enabling environment at the household and community level for children's survival, growth, and development.

Key Household Practices

Key Household Practices

1. Growth promotion and development

2. Disease prevention

3. Home management

4. Care seeking and compliance to treatment and advice

The household and community component of IMCI seeks to address household practices that are key for child survival, growth, and development. The 16 key practices identified and agreed upon by UNICEF/ ESAR, WHO/ AFRO and partners can be categorised into four main areas: growth promotion and development, disease prevention, home management, and care seeking and compliance to treatment and advice.

Growth Promotion and Development

These are practices that help a child grow and develop physically and mentally, and include good nutrition and psychosocial development.

1. Breastfeed infants exclusively for at least 4 and if possible up to 6 months (taking into account WHO/UNICEF/UNAIDS policy and recommendations on HIV and infant feeding).

2. Starting at about six months of age, feed children freshly prepared energy and nutrient rich complementary foods, while continuing to breastfeed up to 2 years or longer.

3. Provide children with adequate amounts of micronutrients (vitamin A and iron, in particular), either in their diet or through supplementation.

4. Promote mental and social development by being responsive to the child's needs for care, and stimulating the child through talking, playing, and other appropriate physical and affective interactions.

Disease Prevention

These are practices in the household before the onset of a disease to provide protection against disease.

5. Dispose faeces (including children's faeces) safely, and wash hands with soap after defecation, and before preparing meals and feeding children.

6. In malaria-endemic areas, ensure that children sleep under recommended insecticide-treated mosquito nets.

7. Prevent child abuse/neglect and take appropriate action when it has occurred.

8. Adopt and sustain appropriate behaviour regarding prevention and care for HIV/AIDS affected people, including orphans.

Home Management

These are practices that take place in the home to help a child once it is realised that the child is sick or unwell in any way.

9. Continue to feed and offer more fluids to children when they are sick..

10. Give sick children appropriate home treatment for illness.

11. Take appropriate actions to prevent and manage child injuries and accidents.

Care Seeking and Compliance to Treatment and Advice

These are practices that involve going out of the home to seek health care. These practices include 1) recognising that a sick child can no longer be managed at home, 2) the process of going out to seek further help, and 3) going out of the home to seek any medical service at all, including preventive services.

12. Take children as scheduled to complete a full course of immunisation (BCG, DPT, OPV, and measles) and Hb as recommended.

13. Recognise when sick children need treatment outside the home and take them for health care to the appropriate providers.

14. Follow recommendations given by health workers in relation to treatment, follow-up and referral.

15. Ensure that every pregnant woman receives the minimum recommended four antenatal visits, recommended doses of tetanus toxoid vaccination, and is supported by family and community in seeking appropriate care, especially at the time of delivery and during the postpartum/lactation period.

16. Ensure that men actively participate in provision of childcare, and are involved in reproductive health initiatives.

These practices are generic and are to be adapted according to the local situation and priorities at country and community levels. It is important to focus on a few key practices that are likely to have the greatest impact on child survival, growth, and development within the available resources.

Criteria for selecting practices at the community level

Key practices should be acceptable, sustainable, and owned by the community. These criteria should guide selection of key practices at the community level.

- Interventions exist that are feasible and affordable by the community.
- Resources are available at the community level and within the health service delivery system.
- The problems being addressed by the practices are the major causes of morbidity and mortality in children under five years of age.
- Community-based interventions or projects exist that can be built upon.
- The problem being addressed is a concern of the community.

Expected outcomes

Through improving the key household practices, HH/C IMCI is expected to improve household and domestic hygiene, parenting practices, feeding practices for children under five years of age, and participation of communities in child health care activities. HH/C IMCI is expected to reduce the prevalence of common childhood illnesses and deaths of children under five occurring in homes. It is expected to increase the utilisation of health services.

Strategies and activities to promote key household practices

To achieve the above objectives and expected outcomes of the household and community component of IMCI, six strategies are recommended:

- Advocacy at all levels to promote political and social commitment, mobilise resources, and stimulate development of supportive policies.
- Social mobilisation for partnership building.
- Programme communication to promote and sustain positive behaviours among key target audiences.
- Strengthening linkages between health facilities, communities and households.
- Improving collection and utilisation of community-based information.
- Building capacity for effective programme implementation.

Strategies

1. Advocacy at all levels

2. Social mobilisation

3. Program communication

4. Strengthening linkages between health facilities and communities

5. Improving community-based information collection and utilisation

6. Building capacity for effective programme implementation

These strategies can be adapted according to each country's specific situation.

Advocacy

Advocacy refers to the process of gathering, organising, and communicating information with a view of gaining political and social leadership acceptance and commitment for a development programme, or raising resources for programme implementation. In this case the development programme is the household and community component of IMCI.

Target audiences. Advocacy for HH/C IMCI targets both formal and informal leaders, as well as influential people in a community. Appropriate individuals vary from community to community, and differ depending on the level (national/regional/community) at which the programme is being implemented.

Aims and objectives. Advocacy strategies and activities aim to

- Inform leaders and influential individuals about the aims, objectives, strategies, activities and benefits of HH/C IMCI.
- Explain the role the community leaders and influential people can play in implementing HH/C IMCI.
- Provide leaders and influential persons with materials they can use to explain the strategy to other people.
- Involve leaders and influential persons in appropriate, concrete activities promoting the desired key household practices.

Social mobilisation

Social mobilisation in the context of HH/C IMCI refers to the process of sensitising and motivating social partners and allies to work together in raising awareness and the demand for improved household and community practices to promote child survival, growth, and development. Social mobilisation efforts will involve collaborating organisations in identifying, pooling, and managing human and material resources to achieve and sustain the HH/C IMCI goals.

Target audiences. Target audiences for social mobilisation are mainly interested organisations, although some individuals with a special contribution to make may also be mobilised. Appropriate organisations include the suitable government departments, NGOs, community-based organisations, religious organisations, trade unions, co-operative societies, professional associations, employers' organisations, international organisations, boy scout organisations, girl guide organisations, schools, media, and advertising companies.

Individuals may include known researchers, lawyers, doctors, counsellors, journalists, business leaders, and others with interests and skills that can benefit the implementation of HH/C IMCI.

Each target for social mobilisation comes with special expertise, resources, and skills. In promoting child survival, growth, and development at the community level, five key partners stand out for their great potential: NGOs, CBOs, religious organisations, schools, and community development committees. Between them, these partners have the capacity to reach virtually every household in most communities.

Aims and objectives. Social mobilisation aims to

- Identify and recruit partners to play a role in the implementation of HH/C IMCI.
- Engage the partners in the planning process.
- Identify roles and responsibilities for the various partners in the implementation of HH/C IMCI.
- Maintain the partnerships and ensure active partner participation.

Programme communication

Programme communication refers to communication designed to inform and motivate key target groups and bring about desired changes in knowledge, attitudes, and behaviour regarding the key IMCI household practices.

Target audiences. The primary target audience in child survival, growth, and development programmes is caregivers. Other primary target audiences that may need to be reached in programme communication include the following:

- community leaders (to disseminate messages, review harmful community practices and facilitate community action),
- local council leaders (to advocate for more funds to support health activities and mobilise communities to participate),
- drug sellers (to sell appropriate drugs in correct doses and educate drug buyers), and
- grandmothers and grandfathers (to support the needed change in cultural practices).

Secondary target audiences may include health workers, traditional healers, traditional birth attendants, community health workers, teachers, and pupils.

Aims and objectives. Programme communication targets key audiences with the aim of bringing about the needed behaviour change and behaviour development. For HH/C IMCI, inter-personal communication is emphasised. If any other method is used, resource persons and mobilisers should study their audiences carefully and place messages where their target audiences can access the information easily. Cost-effective points to places messages on child survival, growth, and development may include homes, points of service (health

facilities, especially maternity wards and ANC clinics), points of sale (pharmacies), places of work, places of worship, and schools.

Establishing linkages between health facilities and communities

Health facilities are centres for health promotion and not merely for treatment. In addition to treating the ill, health facilities should, therefore

- Provide health education to the population at large and child caregivers in particular.
- Educate and motivate communities to recognise and play their roles in health promotion.
- Support communities to develop structures that can promote and sustain broad-based participation in health promotion.

Aims and objectives. The IMCI strategy seeks to bridge the gap between health workers and communities by empowering health workers to

- Improve communication and relations with communities.
- Show genuine respect and concern for community problems and aspirations.
- Work with communities to promote health and improve the health status of the population.
- Visit communities more frequently to provide services, guidance and support to community initiatives.

The IMCI strategy seeks to create a sense of ownership and demand for quality services by the communities in the following ways:

- Community representatives will be encouraged to actively participate in the running of health facilities.
- In participatory ways communities will be involved in all community-based interventions.

Improving community-based information collection and utilisation

Aims and objectives. The IMCI initiative will support communities to collect and utilise information relating to health and development activities they are involved in by

- educating communities about the need to collect information and keep records,
- guiding communities to determine priority health problems,
- working with communities to determine key information to collect about health interventions,
- helping communities to develop simple formats for collecting and keeping information, and
- helping communities to process and utilise the information collected.

Building capacity for effective programme implementation

Target audiences. Key targets for orientation and skills training will include many groups at different levels:

- the national IMCI team,
- District Health Management Teams,
- Sub-district Health Management Teams,
- identified cadres of health workers,
- community leaders,
- Local Council leaders,
- NGO and CBO leaders and staff,
- implementers and participants at local levels, including teachers, pupils, and community resource persons (TBAs, CHWs, etc.),
- extension workers of other ministries and departments,
- media representatives, and
- drug sellers.

Additional cadres may be identified and trained, depending on each country's particular needs.

There may be need to develop appropriate training programmes to equip health workers, facilitators, trainers, resource persons, volunteer motivators, individuals, and communities to participate more effectively in health and related development issues at the various levels.

Training Content. Training will be tailored to the needs of the various trainee groups, and will take local needs into account. The following generic areas of content are recommended for consideration during the process of determining training content for the various programme targets:

- aims and objectives of the IMCI approach,
- strategies for implementing IMCI,
- roles and responsibilities of the various trainee groups,
- resources for planning and implementing CSGD initiatives,
- communication skills,
- using communication materials,
- working with communities,
- data collection and utilisation,
- support supervision, and
- resource mobilisation and management.

Specific content will be determined on the basis of research data and a review of the training needs of categories of trainees.

Implementation

To ensure the successful and sustainable implementation of the household and community component of IMCI, the approach should be flexible and tailored to the needs of the district and communities. It should be guided by the following principles:

- Follow a participatory approach that promotes community ownership and leadership combining a bottom-up and top-down approach.
- Build upon existing positive practices, community-based programs, structures and resources.
- Complement where necessary, but do not substitute for community resources.
- Co-ordinate planning and form partnerships between community-based players and health workers to improve contact between formal health providers and households. Create partnerships for implementation and scaling-up of community-based initiatives.
- Understand and use local knowledge, practices, perceptions and behaviours in relation to maternal health and childcare.
- Ensure gender equity in planning and implementation; reduce gender inequity where it is found.
- Clarify roles and responsibilities to ensure transparency and accountability.
- Focus on the key household practices that will have the greatest impact on child survival, growth, and development.
- Promote learning by doing through the Triple A (Assessment, Analysis and Action) process.
- Implement the three components of IMCI simultaneously, where possible.
- Take a human rights based approach to programming.

Implementation phases

1. Introduction and planning

2. Early implementation

3. Expansion and consolidation

To ensure meaningful community involvement and participation, a gradual and systematic approach is recommended. This is crucial for ensuring sustainable community capacity development and empowerment. Based on country experiences, three phases of implementation are suggested, introduction phase, early implementation phase and expansion phase. This approach is in line with WHO/UNICEF implementation guidelines for components one and two of IMCI. However these proposed steps may be adapted according to each country's specific situation.

Phase 1: Introduction and Planning

National Level

1. Conduct initial discussions to introduce the HH/C component of IMCI. During initial discussions, the concept, content and implementation steps of the household and community component of IMCI are discussed, and awareness is created at the national

level. Where appropriate, the three components of IMCI should be introduced at the same time. Depending on country needs and capacity, UNICEF, WHO, and other key partners may support countries during this important phase of consensus building. The following activities should be undertaken:

- Conduct individual or group meetings with key officials in the Ministry of Health, program managers of the relevant child survival programmes, and partners in order to share information on IMCI.
- Meet with key officials of other relevant ministries.
- Review and assess national policies and treatment guidelines in light of IMCI recommended guidelines.
- Meet with key partners including NGOs in order to provide information on IMCI and assess their readiness to support the approach.
- Plan for a national orientation meeting if the country is ready to embark on the implementation of IMCI.

2. Identify a co-ordinator. The Ministry of Health is to identify and recruit a national level co-ordinator for the household and community component of IMCI with clear terms of reference.

3. Build consensus and sensitise key partners and stakeholders. Meetings and discussions with key partners and stakeholders are crucial for consensus building and acceptance of the strategy. It is important to advocate for their involvement, support, and active participation early to build a sense of ownership.

4. Hold a national level orientation meeting. This is a meeting of key decision-makers of relevant ministries, partners, and other stakeholders. The purpose of this meeting is to

   - Share information and build consensus on adoption of IMCI implementation.
   - Ensure a common understanding of HH/C IMCI concepts, content and implementation steps by all decision-makers, partners, and stakeholders.
   - Ensure understanding of the implications of HH/C IMCI implementation on policies and health care delivery system.
   - Affirm commitment of the country/region and partners to HH/C IMCI implementation.

5. Establish a working group. This working group should be multi-sectoral and multi-disciplinary and should have clear terms of reference. In cases where an IMCI working group for component one and two already exists, this group should be a sub-group of the overall IMCI group. This will ensure

   - The approach is accepted.
   - Key stakeholders build consensus and give input.

- Collaborative planning is done, where possible, and interventions are converged.
- A synergism exists among the three components of IMCI.

6. Select initial regions/districts for implementation. Initially the HH/C component of IMCI should be implemented in a few manageable districts to gain experience.

7. Orient and sensitise key regional and district officials. The national IMCI working group should visit selected regions/ provinces and districts to provide information on HH/C IMCI and to build consensus among key decision-makers and partners.

8. Review relevant information and available resources to inform the planing process. If available information is not adequate, conduct a baseline survey based on the 16 household practices.

9. Identify and adapt key household practices to be promoted at country level. Existing information or findings from the baseline survey should guide this process. The 16 generic practices could be used as an entry point for discussion.

10. Develop a national implementation plan. The national action plan should outline activities that will ensure support for the implementation of IMCI at regional/ provincial and district levels. The action plan should include central capacity building for training, support supervision, development of a communication strategy, development of IEC materials, identification and training of a core team of facilitators and trainers, and resource mobilisation and co-ordination.

Regional/Provincial Level

1. Identify a co-ordinator at the regional/provincial level.

2. Build consensus and sensitise regional/provincial and district officials, and key partners. With support from the national level, the regional/provincial team will carry out preliminary visits to the selected districts in order to sensitise key partners and stakeholders on HH/C IMCI.

3. Hold a regional/provincial orientation meeting. With support from the national level, the regional/provincial team will plan an orientation workshop for key partners and other stakeholders in the districts. The aims of this workshop will be to

   - Share information and build consensus on the HH/C practices adopted.
   - Ensure a common understanding of HH/C IMCI concepts and content by all district decision-makers, partners and stakeholders.

- Ensure understanding of the implications of HH/C IMCI implementation on district development plans, resources, and the health care delivery system.
- Affirm commitment of the region/district and its partners to HH/C IMCI implementation.

4. Develop a regional/provincial implementation plan. This action plan should outline how support is going to be offered to the districts to enable them to work with communities to implement the identified key IMCI household practices.

District Level

1. Identify and recruit a co-ordinator. The District Health Management Team (DHMT) should identify a district level co-ordinator for the HH/C component of IMCI. If the capacity exists, this component of IMCI should have its own specific co-ordinator to drive the implementation forward and to maintain the momentum once implementation is underway.

2. Hold a district level orientation meeting. This is a meeting of key district officials and key partners to share information and reach consensus on adoption of HH/C IMCI strategy and implications for implementation. The purpose of this meeting is the following:

   - Ensure a common understanding of HH/C IMCI and its content by all district decision makers and key partners.
   - Understand the implications of HH/C IMCI on district development plans, resources, and the health care delivery system.
   - Gain the commitment of the district and its partners to HH/C IMCI implementation.

3. Form a district working group. This working group should be multi-sectoral and should have clear terms of reference. This approach will ensure multi-sectoral collaboration, consensus and inputs from key stakeholders, and collaborative planning or joint planning to avoid duplication.

4. Identify the communities. Communities targeted for the early stages of implementation should be selected and informed early during the planning process. Each district will need to develop selection criteria to facilitate this process.

5. Collect and analyse baseline data. If the necessary information and data is not available, districts with support from the national/provincial level should carry out a baseline survey to ensure that reliable information is available for planning, monitoring, and evaluation purposes. This survey will be structured and the findings are intended to be for the benefit and

use of the district. Indicators that will have been set will guide the data collected. Baseline data collection and analysis could include

- adapted and agreed upon key household practices,
- community resource persons and their roles,
- local structures and their roles,
- locally available community resources,
- community-based organisations and existing initiatives, and
- other relevant issues regarding the situation of children and women.

6. Adapt district-specific key IMCI household practices. The key IMCI household practices that would have been adapted at national level should be discussed and adapted according to each district's specific situation, based on available information and resources.

7. Hold initial meetings and discussions with community leaders. This is to enable the DHMT and the IMCI Working Group to understand what is happening in the selected communities that should be taken into consideration during the planning process.

8. Develop a district implementation plan. District priorities, the available information and resources should be used to inform the planning process.

Phase 2: Early Implementation

National/Regional Level

1. Develop HH/C IMCI communication strategy. This is a national-level communication strategy based on the selected key household practices.

2. Adapt or develop IEC materials. National /regional level IMCI teams should adapt or develop, pre-test, produce, and disseminate IEC materials in collaboration with regions and districts.

3. Train a national core team of facilitators/trainers. Include in the training

   - concept, content, strategies and implementation steps of HH/C IMCI,
   - participatory methodologies such as Participatory Learning and Action (PLA), Participatory Rural Appraisal (PRA), Triple A Process, and
   - support supervision and monitoring.

4. Develop a monitoring and evaluation framework. Major activities will include

- adapting and modifying the generic monitoring tools developed by UNICEF, WHO and the IMCI Inter-Agency Working Group,
- identifying national indicators for monitoring and evaluation purposes, and
- planning for documentation.

The monitoring and evaluation framework and indicators should cover

- household management of healthy and sick children,
- good parenting practices,
- community and household participation,
- preventive and promotive aspects of child health, and
- nutrition and feeding practices.

5. Provide overall co-ordination and technical support and advice according to need.

6. Provide support supervision and monitoring. Close supportive supervision and monitoring is crucial, especially in early phases of implementation. For sustainability, support supervision and monitoring of IMCI-related activities and resources should be built within the existing support supervision system at different levels.

7. Evaluate the early implementation phase. In collaboration with the districts and key partners, at the end of the first year an implementation evaluation should be planned and conducted. At this stage of implementation, emphasis should put on progress evaluation rather than impact. Information collected through regular monitoring should be analysed and special studies undertaken where necessary to inform the evaluation process. The findings and recommendations of the evaluation should be taken into consideration when planning for Phase 3 (consolidation and expansion).

8. Provide continuous advocacy and social mobilisation for commitment and resource mobilisation.

District Level

1. Train district facilitators/trainers. Training can include the concept, content, strategies and implementation of HH/C IMCI and participatory methodologies such as PRA or the Triple A process.

2. Adapt the national IMCI communication strategy. The product is a district-focused communication strategy for promoting identified key practices at district level. It should contain messages and strategies for promoting child survival, growth, and development.

3. Develop IEC materials. If capacity and resources are available, develop, pre-test, produce, and disseminate IEC materials with support from the regional/national level when required.

4. Strengthen community development committees.

5. Provide supportive supervision for Community Owned Resource Persons (CORPS).

6. Ensure co-ordination of community development committees.

7. Identify and mobilise the required resources. In order for the HH/C IMCI strategy to succeed and produce the desired impact, households and communities should have easy access to essential drugs and supplies such as antimalarials, ITNs, and weighing scales. This support may be in the form of a revolving fund, grant, or subsidies. This issue must be taken care of early in the planning phase at all levels - national, district and community. There may be need to review or advocate for systems and policies that ensure easy access to essential drugs and supplies by communities. IMCI working groups at all levels, in collaboration with the relevant authorities, should be responsible for mobilisation and ensuring easy access to essential drugs and supplies by households and communities.

8. Monitor progress. Continuous monitoring or periodic surveillance of HH/C IMCI implementation is crucial for its successful implementation. Where feasible, HH/C IMCI monitoring should be part of on-going district monitoring activities. It is recommended for countries to include indicators that have already been developed by WHO and UNICEF in collaboration with the Interagency Working Group on IMCI (See Annex). However, communities, districts and countries may develop additional indicators according to their priorities and specific needs. These indicators should cover

   - household management of healthy and sick children,
   - good parenting practices,
   - community and household participation,
   - preventive and promotive aspects of child health, and
   - nutrition and feeding practices.

9. Document, network and share experiences. Networking and sharing of experience among communities, districts, and countries will be an important element of the implementation process, which should be taken into consideration early in the planning stage.

Community Level

1. Conduct a community needs assessment. Using participatory methods to ensure community involvement and ownership,

facilitators should support community resource persons to carry out a community needs assessment. This assessment is used for the community to identify their own needs, gaps, and priorities and is designed to inform the community's planning and monitoring process.

2. Identify Community Owned Resource Persons (CORPs).

3. Train community resource persons. Training of CORPS should be done according to the identified needs with emphasis on identified key practices at community level, communication skills, and community-based surveillance.

4. Develop community action plans. Using various participatory methodologies that take into account the Triple A analysis model and a mix of bottom-up and top-down approaches, communities should develop their implementation plans. In this process, the key household practices identified at district level should be used as an entry point for discussion and situation analysis.

5. Implement identified interventions. This could involve household visits, community meetings, communication campaigns, or service provision.

6. Conduct community-based surveillance. With support from the district, communities should develop their own surveillance system based on locally identified indicators. Where possible the community-based surveillance system should be built within the district health information system.

Phase 3: Expansion and Consolidation

Planning for consolidation and expansion of the HH/C component should be based on the experiences and lessons gained from the early implementation phase.

Expansion should be gradual and phased to cover more communities within the districts and more districts within the country. Existing opportunities, limitations and available resources should be taken into account during the re-planning process.

Annex

Priority Indicators for the Household and Community Component of IMCI

Nutrition
- Child less than 4 months of age is exclusively breastfed.
- Child aged 6 – 9 months receives breast milk and complementary feeding.
- Child under 2 years of age who is low weight for age (underweight prevalence).

Prevention
- Child 12 – 23 months of age is vaccinated against measles before 12 months of age.
- Child sleeps under an insecticide treated net (in malarious areas).

Home case management
- Sick child is offered increased fluids and continued feeding.
- Child with fever receives appropriate antimalarial treatment (in malaria risk areas).

Care seeking
- Caretaker knows at least two signs for seeking care immediately.

Proposed Supplemental Indicators for Community IMCI

Nutrition
- Continued breastfeeding rate of children aged 12 – 15 months
- Complementary feeding frequency
- Stunting prevalence
- Wasting prevalence
- Mean weight for age Z-score
- Mean height for age Z-score
- Mean weight for height Z-score

Prevention
- DPT vaccine coverage
- Polio vaccine coverage
- Tuberculosis vaccine coverage
- Vitamin A supplementation

Home case management
- Ownership of mother's card for children under 2 years

Morbidity
- Prevalence of night-blindness
- Period prevalence of history of fever
- Prevalence of malaria parasitemia
- Period prevalence of diarrhoea
- Period prevalence of acute respiratory infections needing assessment

Lists proposed by the IMCI Inter-agency Working Group.

Indicators proposed in the Multi Indicator Cluster Survey (MICS) should be considered where appropriate.