

C-IMCI
Program
Guidance

Community-based
Integrated
Management of
Childhood
Illness

January 2009



Summary

This document provides an overview of the Community-based Integrated Management of Childhood Illnesses (C-IMCI) framework. The C-IMCI framework consists of three elements and a multi-sectoral platform that focus on specific behaviors and practices of health workers and caregivers of young children. Included in this document: the history of C-IMCI's development, its elements, benefits, and rationale for use.

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Community-based Integrated Management of Childhood Illnesses (C-IMCI): Program Guidance

What is C-IMCI?

In 1992, the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) developed the Integrated Management of Childhood Illnesses (IMCI) strategy to address the five major causes of child mortality -- diarrhea, pneumonia, malaria, measles and malnutrition. The cornerstone of the IMCI strategy was the development of standard treatment guidelines and training of health workers.

In subsequent years, global health experts recognized that success in reducing childhood mortality requires more than the availability of adequate services with well-trained personnel. Around the world, many children do not have access to health facilities due not only to distance, but to barriers related to cost, health beliefs, and language. Additionally, because families bear the major responsibility for caring for children, success requires a partnership between health providers and families with support from their communities. Health providers need to ensure that families can provide adequate home care to support healthy growth and development of their children. Families also need to be able to respond appropriately when their children are sick, seeking appropriate and timely assistance and giving recommended treatments.

In 1997, Community IMCI, improving household and community practices, was added as the third component of a comprehensive IMCI strategy (1. Improving the skills of health workers; 2. Improving health systems; and 3. Improving household and community health practices.) Community IMCI, or C-IMCI, focuses on the role of sixteen key health practices within the household and community.

What are the benefits of C-IMCI programming?

C-IMCI programs are flexible, cost-effective and responsive to community needs. They enable nongovernmental organizations (NGOs) and governments to categorize their existing community-based programs and develop a coordinated strategy to improve child health. The C-IMCI framework includes three elements and a multi-sectoral platform that focus on specific behaviors and practices of health workers and caregivers of young children. Each of the elements focuses on an institution, or set of people, with a critical role to play in efforts to promote appropriate child care, illness prevention, illness recognition, home management,

care-seeking and treatment compliance practices. Investment in these community institutions leaves a structure that ensures child survival work will continue into the future.

C-IMCI programs' comprehensiveness and sustainability make them an excellent value. For example, in its 1999-2003 Vurhonga II Project in Mozambique, World Relief reported that the average cost per direct beneficiary was US\$6.65 per year, including USAID funding and match funding from World Relief (including indirect cost recovery). In World Relief's Malawi project, which ran from 2000 to 2004, the annual cost per beneficiary was US\$4.84. In its 2001-2006 Rwanda project, the annual cost per beneficiary was US\$6.37.¹ This includes start-up costs, such as program design, training, outside evaluations, technical backstopping, headquarters staff visits and indirect cost recovery.

Once a program is operational, it becomes more efficient, and less costly. Among 32 U.S. Agency for International Development (USAID)-funded child survival programs ending in the period from 2005 to 2007, the median cost per beneficiary per year was US\$5.55, for a median beneficiary population of 72,700.² The median length of these programs was four years.

Programming with C-IMCI also produces results. World Relief's current, expanded impact child survival project (2005-09) in Malawi's Chitipa District, for example, reported the following mid-term results for a beneficiary population of about 90,000.

Over two years:

- care-seeking for childhood illness increased from 71% to 84%;
- childhood vaccinations increased from 69% to 96%;
- vitamin A dosing increased from 54% to 82%; and
- exclusive breastfeeding jumped from 40% to 82%.

What are the elements of C-IMCI?

The C-IMCI framework consists of three elements and a multi-sectoral platform, as described below. For the purpose of illustration, we offer examples of how one international NGO, World Relief, headquartered in Baltimore, Maryland, has implemented each element in its field work. It is important to note that many other international NGOs are active in C-IMCI programming as well.

¹ Laughlin, M., *The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Health Educators*, World Relief, 2004, p. 30.

² Ricca J., USAID-supported NGO Child Survival projects demonstrate that community-based approaches have high impact and cost effectiveness. Paper presented to the American Public Health Association Conference, Washington, DC. November 5, 2007.

1. Improving partnerships between health facilities and the communities they serve.

The first element focuses on increasing the use of formal health services and outreach services through the formation of equitable partnerships that include community input into health services and participation in management of health facilities. Activities under this element include joint village level outreach by community and facility-based providers, collaborative oversight, management and supervision of health services by community committees, and collaboration on community-based health information systems.

Example: In Malawi, World Relief established community volunteer “care groups” (see description under element 3) to feed vital information—births, deaths, and health events—into the Community-based Health Information System (C-HIS). Community volunteers compile key data biweekly and report it upward through World Relief’s local care group “promoters,” so that information can be aggregated for each village and district. Instead of blindly passing information along, however, volunteers discuss their findings together during biweekly care group meetings and act upon them. For example, the group might discuss how to introduce change in a household that resists key health practices or appoint a delegation to help mobilize resources for a family in need.

World Relief staff and care group volunteer leaders report C-HIS results to both the Ministry of Health and community members, using graphs suitable for low literacy audiences where appropriate. The C-HIS is thus useful not only as a monitoring tool, but to help community leaders, village health committees, and the Ministry of Health make timely and responsive decisions.

2. Increasing appropriate and accessible health care and information from community-based providers.

Community-based providers often are the first point of contact for both care of sick children and provision of health information. They include community health workers and other volunteers, traditional healers and midwives, physicians in private practice, and unlicensed providers such as drug sellers or shopkeepers. Together, their practices often surpass the formal health system in terms of patient volume because they may be the most accessible sources of care at the community level. In this element, disease control programs and NGO child health programs across the world work to improve the diagnostic and treatment skills of these providers.

Example: In Mozambique, World Relief revived and revitalized the role of community-level first aid workers, referred to as *socorristas*, as part of a child survival program. During the project, socorristas were appointed by village health committees and trained to dispense chloroquine

(at that time the first-line treatment for malaria), oral rehydration solution packets, Mebendazole, eye ointment, iron tablets, and aspirin in addition to first aid care for wounds. World Relief and MOH staff also trained them to identify and refer pneumonia, malnutrition, and diarrhea to health centers as appropriate. The committees authorized a service fee, fully competitive with traditional practitioners, which included the consultation and medicine that socorristas were authorized to dispense.

3. Integrating promotion of key family practices critical for child health and nutrition.

Element three focuses on the practices of parents and other caretakers of young children at the household and community levels. Promotion of practices critical for child health and nutrition has long been the cornerstone of child health programs. The task facing C-IMCI is not how to implement single interventions or program components such as oral rehydration therapy promotion, immunization or promotion of exclusive breastfeeding, but how a program can promote a whole range of key family practices without sacrificing the effective characteristics of the single intervention-focused programs.

Communities need to be empowered to take responsibility for their own health. This means that communities must develop a sense of ownership over the key practices, and assume responsibility for practicing and promoting them over the long term. Participatory research methods and community-based monitoring and evaluation efforts are important tools for communities to learn about and assume responsibility for these behaviors.

Example: In Mozambique, Rwanda and Malawi, World Relief introduced a volunteer care group model as a cost-effective strategy to implement a broad range of health interventions for a large population. Under the model, World Relief project staff (promoters) work through small care groups of volunteers, each of whom is responsible for ten households neighboring her own.

Each paid World Relief promoter is assigned about eight care groups to meet with biweekly for training and support. Throughout the week, volunteers visit their assigned ten homes to teach family members key messages about prevention and care-seeking practices. Volunteers also collect vital data regarding births, deaths and public health concerns. Through the model, volunteers can reach 800- 1,800 households, depending on the population density of their village.

World Relief's use of the care group model in Mozambique achieved the following results for malaria control in its 1999-2003 child survival project, for a beneficiary population of about 53,000:

- Increased use of insecticide-treated nets by pregnant women and children under 2 years of age, from 1% to 85%;
- Improved community access to health facility and essential drug treatment, from 65% to 99%; and
- Improved care-seeking practices: Percent of children under 2 years seen at a health facility within 24 hours of malaria symptoms increased from 28% to 90%.

Multi-sectoral platform: *Linking health efforts to those of other sectors to address determinants of ill health and sustain improvements in health.*

The multi-sectoral platform includes the three linked elements of the C-IMCI framework but is also comprised of all the social, economic and environmental factors that facilitate or hinder the full health of children. The adoption of key family practices alone does not assure the health of children. Children thrive when their families have sufficient income, when they have access to education, when they have clean water and sanitation and when government and civil authorities protect and nurture their welfare. C-IMCI, then, is most effective when it is a part of a multi-sectoral strategy.

Example: Working in Rwanda's Kibogora Health District, World Relief recruited pastors from 11 denominations to participate in monthly pastoral care groups for C-IMCI. World Relief staff trained 667 church leaders in family planning methods; these leaders in turn helped communities accept contraceptives. Contraceptive use increased from 3% in November 2001 to 18% in September 2005. At the end of World Relief's program, Kibogora Health District ranked first nationwide in family planning coverage, for which the MOH awarded the district a certificate of merit. Pastoral teaching in Rwanda also helped people understand how AIDS is spread, and broke down barriers to caring for an HIV-positive person in his or her home.

Why is it important to work with NGOs in programming for C-IMCI?

NGOs collaborating with the MOH can provide valuable guidance and support for Ministries to reach their Millennium Development Goals. Ministries can be overwhelmed with coordinating donor and NGO programs, and have no staff to evaluate every program in their country. NGOs not only provide evidence of which local approaches are effective, they recruit and train program staff from local districts, then leave trained community members and caregivers in place at the end of the program. This community structure helps to sustain not only future child survival work, but work in other sectors, such as income generation and disaster relief. Many NGO C-IMCI programs are reporting excellent results; Ministries should seek these programs out and look for ways to scale them up.

One example of how an NGO worked successfully with MOH staff on IMCI programming occurred in Malawi, where World Relief staff helped the Ministry monitor quality of IMCI services by meeting monthly with the district planning secretariat. The two parties jointly reviewed data on quality of care, service utilization, drug supply and management, and developed initiatives for improving quality of IMCI services. The World Relief child survival program director is currently a member of the national IMCI Working Group, which provides essential feedback to influence national and district IMCI policy.

How can I find an NGO partner for C-IMCI programs in my country?

For more information on international NGOs who are implementing the C-IMCI framework, and how to partner with these NGOs, contact the Washington, DC- based CORE Group. The CORE Group is a membership association of international NGOs whose mission is to improve the health and well-being of children and women in developing countries through collaborative NGO action and learning. Collectively, CORE Group members work in more than 180 countries.

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