

1. OBJECTIVES

The Ministry of Health and Population (MOHP) of Egypt, in collaboration with the Regional Office for the Eastern Mediterranean (EMRO) of the World Health Organization (WHO), conducted a survey from 10 March to 10 April 2002 on the quality of outpatient care provided to children below 5 years old at health facilities by health providers trained in the Integrated Management of Childhood Illness (IMCI).

The “IMCI health facility survey” in Egypt more specifically had the following objectives:

- (1) To assess the *quality of outpatient care*, including both clinical and counselling care, provided at health facilities to sick children aged 2 months up to 5 years old¹ by health providers trained in IMCI;
- (2) To describe *organizational and managerial factors* (“health systems support”) influencing the quality of care and identify major constraints to it;
- (3) To measure *key indicators* of quality care to monitor progress of the IMCI strategy at health facilities; and
- (4) To recommend *further approaches* to improving the quality of outpatient care.

2. BACKGROUND

This section summarizes information that was reviewed to discuss survey objectives, adapt the survey questionnaires and develop country-specific survey rules. This information was also used as background to the analysis and interpretation of the results of the survey.

2.1 SETTING

Almost all (98%) the population in Egypt, estimated at almost 68 million, lives in the Nile valley and its delta (5% of the total area)². Being mostly concentrated in a narrow area, it usually has *accessibility* to the wide primary health care (PHC) network of the MOHP, which consists of over 4000 health facilities – the average number per district varying greatly – and represents the backbone of the health system. More than half of the population (about 55%) lives in *rural areas* and about 80% of the PHC facilities is located in these areas.

2.2 CHILD HEALTH INDICATORS

Infant (IMR) and under-five (U5MR) mortality rates have been declining considerably in Egypt over the years, falling from 98.3 to 43.5 deaths per 1000 live births (IMR) and from 140 to 54.3 deaths per 1000 live births (U5MR), respectively, in the period 1980–2000, according to the latest Egypt Demographic and Health Survey carried out in the year 2000 (EDHS2000) (Fig. 1). Thus, 80% of childhood³ deaths occur in the first year of life.

¹ The expression “up to 5 years old” in this report refers to children less than 5 years old, therefore excluding the day of their 5th birthday. This expression, although not fully correct, is used here as it appears to be more easily understood by readers without epidemiological background.

² Sources in this section include MOHP, WHO (WHO World Health Report, 2001) and UNICEF (The State of the World Children, 2002).

³ Childhood in this report refers to children below 5 years old.

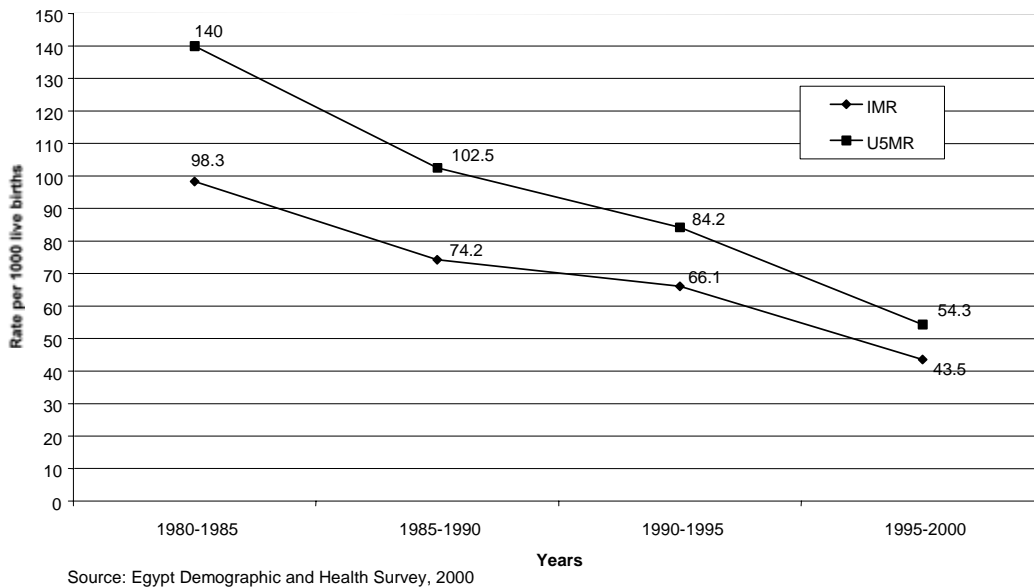


Fig. 1. **Infant and under-five mortality, Egypt, 1980–2000**

There are remarkable differences between urban and rural areas and Lower and Upper Egypt, with IMR and U5MR in rural areas in Upper Egypt being almost twice as high as urban areas in Lower Egypt. This is important when prioritizing public health interventions designed to impact on child mortality. While little difference exists in mortality between boys and girls, mother-related risk factors for child mortality include among others young maternal age (< 20 years old) and short birth interval (< 2 years). Acute respiratory infections and diarrhoeal diseases represent about half of the deaths in under-5 children in Egypt and are responsible for some 39% and 20% of outpatient consultations at PHC facilities, respectively; they are also a common reason for hospital admissions⁴. Malnutrition is also not uncommon: almost a fifth (18.7%) of children below 5 years old was found stunted (< -2 SD for height-for-age) in the EDHS2000.

2.3 THE RESPONSE: AN INTEGRATED CHILD CARE STRATEGY (IMCI)

The strategy on Integrated Management of Childhood Illness (IMCI) was formally introduced in Egypt in 1997 “as a suitable strategy to meet the needs of the PHC programme, which was confronted with difficulties in integrating child care vertical programmes”⁴. IMCI was included in the “Basic benefit package” of the Health Sector Reform, which had been developed at the time. The main steps of the IMCI process in Egypt from introduction through the early implementation phase are shown in Annex 2. An IMCI working group was formally established in 1997 to coordinate activities. Taking into due consideration the marked urban–rural and Upper–Lower Egypt differentials in health and socioeconomic indicators, the strategy has since its inception been implemented in Upper Egypt. In the past 2 years, the strategy has been expanding to cover some 600 health facilities in 32 out of 82 districts located in 10 governorates. Five of these 10 governorates are in Upper Egypt. Among the main adaptations to the generic WHO/UNICEF clinical guidelines are: the inclusion of the management of sore throat, the separation of the management of anaemia and malnutrition, the removal of malaria and the extension of the recommendation for exclusive breastfeeding to the first 6 months of life.

⁴ Report on IMCI early implementation phase – December 1996 – March 2000, PHC sector, MOHP, Cairo, April 2000.

The main focus of the strategy has initially been on the health system.

- ❖ *Improving health providers' skills* – A total of 90 clinical training courses on IMCI have been conducted for almost 2000 people from PHC facilities and hospital outpatient departments (Annex 3). While doctors undergo the standard 11-day training, a 4-day training package has been developed for nurses focussing on selected tasks, to improve the distribution of case management tasks and responsibilities among health facility staff. About 95% of health providers trained have been followed up with skill reinforcement visits within 4–6 weeks of the training course (“IMCI follow-up visits”). One issue has been the turnover of trained staff; training slots have been reserved in new courses to train new staff in the facilities already covered where trained staff have left (“IMCI facilities”). IMCI elements have also been introduced in the teaching at seven medical schools, to address the issue of long-term sustainability. Medical graduates from the first batch of medical students exposed to IMCI are currently going through their one-year internship as house officers and will soon be ready to enter the health system.
- ❖ *Improving the health system* – A review of the essential drug list has been undertaken, with basically all drugs needed for IMCI included. A standard approach has been used to improve health system support to child care, with proper orientation of governorate and district authorities, selection of districts based on agreed upon criteria, followed by situation analysis and district planning. As a result of those plans, basic supplies and equipment have been provided to IMCI-implementing facilities and efforts have been made in coordination with local authorities to ensure adequate supply of the required drugs. Work at ‘IMCI health facilities’ has been re-organized to make patient flow smooth, detect severe cases promptly and manage cases systematically, distributing selected tasks to nurses. Case record forms have been developed and distributed and an information system has been developed. To encourage caretakers to take their sick children back to the facility for follow-up visits when required, follow-up visit fees have been waived. Attention has recently been paid to supervision and a supervisory skills training package has been developed.

Activities to improve *family and community practices* have initially focussed on collection of baseline data from, and assessments of, a few communities.

3. SURVEY METHODOLOGY

The survey consisted of the following main phases (Annex 4): planning (one week), training of surveyors and supervisors (one week), data collection and data entry (11 days), data cleaning (2 days), data analysis (one week), and presentation and discussion of the findings and recommendations.

3.1 PLANNING

Plans for the survey were developed from 2 to 6 December 2001 by a national planning team of the MOHP in close collaboration with WHO. The planning team included: the national IMCI coordinator and four other members of the IMCI team at central level, among whom was the chairperson of the working group on IMCI community component; a four-member WHO team from the country, regional and headquarters levels; and a representative from John Snow, Inc. (JSI). Staff from the United States Agency for International Development (USAID, Cairo) were able to join some of the sessions. As this was the first time that such a survey was conducted in a country of the WHO Eastern