

EXECUTIVE SUMMARY

Background

Integrated management of childhood illness (IMCI) was introduced in Egypt in 1997 to integrate vertical child health care programmes under the primary health care programme. It has since expanded to cover some 600 health facilities in 10 governorates. This survey was planned to measure outcome indicators (quality of care) at IMCI health facilities.

Methods

The management was observed of 296 children aged 2 months up to 5 years with an 'IMCI' condition seen at 50 health facilities, randomly selected from 294 IMCI facilities that had a daily caseload of at least four children under 5 years, including rural and urban health centres, and outpatient departments of hospitals, in 10 governorates. 292 interviews with child caretakers were also conducted, and facilities, services and supplies were assessed in the 50 facilities visited.

Results

Two-thirds (66%) of cases were among children under 2 years old and all the 6 severe cases fell in this age group. Fewer female children than male children tended to be seen at rural facilities. The majority of caretakers (85%) were mothers of the sick children. About a quarter (27%) of children had 'anaemia' based on clinical pallor. About one child in 20 (5%) was low weight-for-age. Most of the conditions seen were mild and required just home care.

Assessment: About half (47%) of children were systematically checked for all the 10 main assessment tasks and most (83%) of those below 2 years old and with low weight-for-age and/or anaemia were assessed for feeding practices. Children seen by female doctors tended to be more thoroughly assessed than those seen by male doctors. All children were weighed, had temperature taken and immunization status checked. The respiratory rate was taken in 97% of the children with cough or breathing problems and the count was considered reliable in two-thirds (65%) of them. In most children, key tasks were performed and done correctly to check for a throat problem, detect clinical pallor, and assess such conditions as diarrhoea and ear problems. A history to check about measles was taken in 3/4 (74%) of children with fever or history of fever. Over two-thirds (69%) of children were asked also about problems other than those covered by the IMCI clinical guidelines. Child health cards were checked in 58% of cases.

Classification: For the conditions identified, there was agreement between provider and surveyor classification in 73% of cases. All but one (99%) of the conditions incorrectly classified by the provider were under-classified as milder cases, including especially cases with 'pneumonia' and 'anaemia'.

Treatment and advice: One of the six severe cases needing urgent referral or hospital admission was fully managed, while two others were admitted with no initial treatment. Injectable drugs, including antibiotics, were properly used. About 3/4 (73%) of cases needing oral antibiotics were prescribed antibiotics correctly; antibiotics were unnecessarily prescribed to less than 5% of cases. The weak area in providers' antibiotic instructions and caretaker recall was the duration of treatment. Only 45% of caretakers stated that, if the child got better before completing the whole course of antibiotic as advised, they should continue the treatment for the full duration advised by the provider. Most caretakers of children with diarrhoea were advised on ORS and its preparation and use, and two-thirds of them (67%) recalled all the instructions correctly. Other treatments (paracetamol for fever, iron for anaemia, safe remedies for cough) were prescribed in most cases as appropriate. Iron supplements were given in 3/4 (76%) of eligible children. All children but one needing vaccination left the facility with the required vaccinations or advice on when to come back for it. Advice on

definite follow-up would have been required in as many as 73% of all children seen based on the guidelines, raising some issues about the feasibility of such a recommendation. Although most caretakers were advised on home care (feeding, fluids and when to seek care), only 21% of them were clear about all the three key home care rules and, especially, the danger signs that should prompt them to seek immediate care. Overall, more than 2/3 (71%) of target children received age-appropriate advice on feeding, while only 57% of those 6 to 11 months old were properly advised on the frequency of complementary feeding. One mother in five (21%) received some advice on her health.

Health systems: The large majority of caretakers (95%) were satisfied with the health services provided, valuing provider examination of the child, treatment given, and information received – all prominent features of the IMCI approach. Flow of patients was smooth in most facilities and IMCI tasks were well distributed between doctors and nurses. Three-quarters (77%) of first-level, non-hospital facilities had at least 60% of doctors trained in IMCI; 65% of children were managed by doctors who had been trained in IMCI in the past year. Drugs were available, with an average of 5.8 out of the 6 essential oral drugs for treatment of pneumonia, dysentery, diarrhoea, fever and anaemia, 11.2 out of 12 key drugs for IMCI conditions, and all the 3 parenteral drugs recommended for pre-referral treatment. All non-hospital facilities had supplies and equipment for vaccination, and most had other basic supplies and materials; mother counselling cards on childcare were found in 78% of facilities. Transportation for referred cases was not reported as a problem, with an average time of 15 minutes to reach the referral facility. Virtually all facilities reported to have child health services available 7 days a week. Two-thirds (64%) of facilities had a supervisory book and less than half (44%) had recommendations recorded in it. Case management practices had been observed in a third (36%) of the most recent supervisory visits. About a quarter of all outpatient visits recorded in a reference month were for children below 5 years old.

Conclusions

Caretakers highly appreciated the child health care services provided. The management of sick children seen by providers trained in IMCI followed a systematic approach in most cases and drugs were used rationally. Key supportive elements of the health system were in place in the IMCI facilities visited. The IMCI strategy therefore seems to act as a powerful channel to improve the quality of services. Better links should be established between IMCI and mother care. Case management areas needing improvement are described in detail in Annex 1.

Recommendations

1. Plans for a revised approach to training should be developed to address the issue of staff turnover and the challenge of increasing training coverage while expanding to more facilities.
2. Clinical and communication skills of medical graduates already exposed to IMCI in medical schools should be assessed, to help address the challenge of long-term sustainability of IMCI.
3. The impact of the current iron supplementation policy should be measured to review the issue of anaemia in children (and mothers).
4. The use of the child health card should be widely promoted, childcare messages should be incorporated in it and home care and care-seeking practices should be priority areas for community interventions.
5. Childcare drug expenditure by IMCI and non-IMCI providers should be estimated to document improved drug availability at no extra cost through rational prescribing by trained providers.
6. Priority should be given to testing and close monitoring of the approach to strengthening supervision currently under development.