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Integrated Management of Child Health

Guide to planning for implementation of IMCI at district level

World Health Organization
Regional Office for the Eastern Mediterranean

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Contents

Foreword

In the Name of God, the Compassionate, the Merciful

The Integrated Management of Child Health (IMCI) strategy is defined in the Eastern Mediterranean Region as the primary child health care strategy. It encompasses a range of cost-effective interventions under its three key components: human resources development, improving related health system elements and improving family and community practices. Human resources development includes building capacity in planning, child case management and supervision.

Planning is a process based on situation analysis that defines who does what, when, how and for how much. A set of well defined indicators should be included to monitor the implementation of the plan of action. Planning should always identify monitoring mechanisms.

Proper planning is crucial for the successful implementation of any programme and should take place at all levels. District health staff have a crucial role in planning for and implementing public health approaches, including their monitoring, more so in an increasingly decentralized system. They play a critical role in the planning process, which helps to provide a sense of ownership and commitment towards the plan. Public health experience over the years has clearly demonstrated the need to build planning capacity at all levels, particularly at district level.

It is with this aim that the WHO Regional Office for the Eastern Mediterranean has developed this guide to assist in improving the overall planning process and especially in building the planning capacity of district staff. The guide provides planning principles, a standardized step-by-step process, tools and criteria for quality planning and programme implementation.

I hope that this document will be of practical value to countries and will contribute to improving the quality of services delivered to our children—our future.

Hussein A. Gezairy MD FRCS
Regional Director for the Eastern Mediterranean

Acknowledgements

This is one of a series of publications developed by the WHO Regional Office for the Eastern Mediterranean to support countries in their efforts to improve child health and quality of child health services through integrated approaches. The experience of countries in planning for IMCI implementation at district level has been a valuable resource in the preparation of this document. The publication was prepared by Suzanne Farhoud, Regional Adviser Child and Adolescent Health and Development, and Ahmad Nagaty, WHO Programme Officer, IMCI, Egypt, and reviewed in a consultation held in the Regional Office. WHO thanks the reviewers for their valuable contributions. The reviewers were: Ahmad Shadoul, WHO Pakistan, Faiza Mejeed, WHO Iraq, Mohamad Rahman, WHO Pakistan, Sergio Pieche, WHO Regional Office for the Eastern Mediterranean, Sumaia Al Fadil, WHO Sudan, Igbal Abu Karig, Federal Ministry of Health, Sudan, Mohammad Abdel Moneim, Ministry of Health and Population, Egypt, and Mona Rakha, Ministry of Health and Population, Egypt. The guide was field tested in Egypt in 2008 with the participation of IMCI coordinators from six countries of the Region.

About this guide

Why we need this guide

Planning is a process that requires specific skills. Experience has shown the need to develop the planning capacity of health authorities at all levels. Although an integrated management of child health (IMCI)[1] guide for planning at national level is available[2], until now a guide that will direct the IMCI planning process at the district level has not been available. The WHO Regional Office for the Eastern Mediterranean undertook development of this planning guide in order to assist countries to plan for IMCI implementation at the district level, and also to build the planning capacity of district health teams throughout the process.

Because the IMCI strategy is an integrated approach, managers and staff of related child health programmes need to work closely together. While IMCI operational activities are planned and implemented at the district level, some important functions remain at central and governorate[3] levels, such as policy and guideline development, and setting minimum criteria for quality and supervision. This guide describes the planning process for IMCI implementation at the district level, including conducting district planning workshops. These workshops bring together decision-makers and concerned health authorities from the different departments, programmes, partners and institutions, whether at central, governorate or district level. The guide provides an outline for a standardized process, while allowing room for adapting the methodology according to the specific country situation and available resources (human or financial) supplies and equipment at district level.

Who should use this guide

This guide is intended for the health authorities at all levels that are responsible for planning IMCI implementation at district level. The methodology described will also be useful for district teams responsible for planning other programmes at the district level.

How to use this guide

The phases and steps suggested for planning IMCI implementation at the district level are described in a flowchart in Chapter one, and the guide is organized accordingly. A section of the flowchart appears at the beginning of each chapter to illustrate the steps described. To prepare for and conduct a certain step, the guide should be studied carefully, and adapted as needed, ensuring that all necessary preparations are complete. Implementation should then be carried out with reference to the guide wherever necessary. A CD accompanies the publication and contains the orientation package, tools for data collection, and all the templates that will be used during the district planning workshop, for use and adaptation by countries.

[1] IMCI generically refers to the Integrated Management of Childhood Illness. In the Eastern Mediterranean Region, IMCI stands for 'Integrated Management of Child Health', where equal attention is given to both healthy and sick children.

[2] *IMCI planning guide: gaining experience with the IMCI strategy in a country,* Geneva, World Health Organization, 1999 (unpublished document no. WHO/CHS/CAH/99.1).

[3] Governorates denote either governorates, provinces or states according to the term used by different countries.

Definitions and abbreviations

Definitions

Target: objective or result that is aimed at; a desired outcome that is explicitly stated, e.g. to achieve 90% of timeliness of reporting, 100% completeness of reporting, etc. The time-frame is an integral part of the target statement, e.g. by end of 2007, 60% of health facilities will be implementing IMCI.

Indicator: variable that helps to measure change, directly or indirectly.

The indicator should be expressed in number, proportion or rate. Indicators are either:

- Input indicators: measure elements needed to undertake a process.
- Process indicators: monitor whether planned activities took place.
- Output indicators: monitor immediate result of activities.
- Outcome indicators: assess what changes are brought about by the programme/activities within the target group in a specific time-frame.
- Impact indicators: evaluate overall changes in the health status of the target group brought about by the programme/activities over a long period of time.

Planning: the process of setting objectives, targets and indicators for programme implementation based on situation analysis, selecting interventions, deciding on activities and scheduling their implementation, indicating time-frame, responsibilities and funds. Monitoring, evaluation and re-planning are essential components of planning. Plans can be strategic or operational, long-term or short-term.

Supportive supervision: a process that is undertaken by all levels (central, governorate, district or health facility level) to strengthen skills of planners, programme managers, supervisors and health care providers. In this guide, the focus is on the supervision at health facility level which aims at strengthening the skills of health care providers, solving problems and improving the quality of health system support.

Patient flow: the circuit of patients within the health facility in order to receive all components of the health care service.

Completed registers: registers which are filled in correctly with relevant information, and are up to date.

Abbreviations

ARI	Acute respiratory infection
CBI	Community-based initiative(s)
CDD	Control of diarrhoeal disease
DHO	District health officer
DTC	Diarrhoea treatment corner
EPI	Expanded Programme on Immunization
HF	Health facility
HIS	Health information system
IMCI	Integrated Management of Child Health
MCH	Maternal and child health
NGO	Nongovernmental organization
OPD	Outpatient department
ORS	Oral rehydration salts/solution
PHC	Primary health care
POA	Plan of action

Guide to planning for implementation of

IMCI

at district level

Chapter 1. Introduction

Chapter 1. Introduction

IMCI in the Eastern Mediterranean Region

Implementation of the IMCI strategy in countries should address equally the following three components:

- improvement of case management skills of health staff through the development and use of the country specific adapted IMCI guidelines;
- strengthening relevant elements of the health system required to improve quality of health services delivered to children;
- improving key family and community practices related to child health, thereby empowering them to play an active role in child care, both in health and during sickness.

The experience of WHO's Regional Office for the Eastern Mediterranean in implementing IMCI is distinguished by the following characteristics.

- IMCI in the Region stands for 'Integrated Management of Child Health', where equal attention is given to both healthy and sick children.
- The three IMCI components are planned and implemented simultaneously.
- Emphasis is placed on the importance of improving the relevant health system elements prior to training health care providers, in order to create the necessary environment for them to deliver quality services to children.

The factors that have direct relevance to, and have an effect on, the quality and sustainability of health services delivered to children are:

- existence of a functional coordinating management structure at all levels
- good planning
- quality of health care providers' performance
- supportive elements of health system, namely:
  - medicine management and medicine availability
  - availability of basic equipment and other supplies
  - functional health information system (HIS)
  - appropriate organization of work at health facility
  - supportive supervision
  - functional referral system
- stability of trained health staff
- accessibility and affordability of health services.

Planning principles

Planning is a management function concerned with defining goals, tasks and resources required to attain those goals. Good planning is the development of a plan of action with a clear set of objectives, targets and indicators, deciding on interventions and activities, identifying responsibilities, a clear time frame, and appropriate sources of funds. This is crucial for successful implementation, and to ensure monitoring of the quality. To be realistic and evidence-based, the plan should be based upon a situation analysis and most likely available resources. The planning process involves team work, where all concerned players should be actively taking part.

There should be one national IMCI plan for the country, to which all partners should comply. Therefore, coordination between governorates and national levels throughout the process of IMCI implementation is crucial to avoid duplication, ensure quality implementation, and to achieve universal coverage.

District planning

Plans of action for IMCI implementation differ not only from country to country, but also from district to district within the same country and the same governorate. This is because districts may be different in terms of demographic characteristics, epidemiological patterns, health indicators, infrastructure, available resources, staff commitment, etc. In all cases, IMCI implementation in the selected district(s) should aim to achieve 100% implementation before moving on to other districts within the same governorate. For successful IMCI implementation, realistic and feasible district-specific plans need to be developed based on a situation analysis. The situation analysis should also take into account existing child health programmes and functioning/ active partners in the district.

IMCI implementation at governorate and district levels is part of the national IMCI plan of action, despite the fact that the national plan of action does not detail operational activities at governorate or district level. The central team should guide all phases of the planning process at district level to ensure that district plans are part of one national plan for achieving national targets. Governorates and districts are identified on the basis of a set of selection criteria.

Objectives of district planning

- Decentralize management and planning processes by involving the sub-national levels.
- Develop a realistic detailed plan of action for IMCI implementation at district level (as part of the national plan), with full involvement of all concerned health officials and partners in response to the community's actual needs.
- Identify the role, and obtain the commitment, of concerned officials and partners for implementation, which should follow the plan of action.

Phases of district planning

Three phases are identified for the process of developing a plan of action for the implementation of IMCI at the district level:

- preparatory phase
- district planning workshop
- monitoring the implementation of the plan of action

Each phase entails a number of steps as shown in Figure 1.

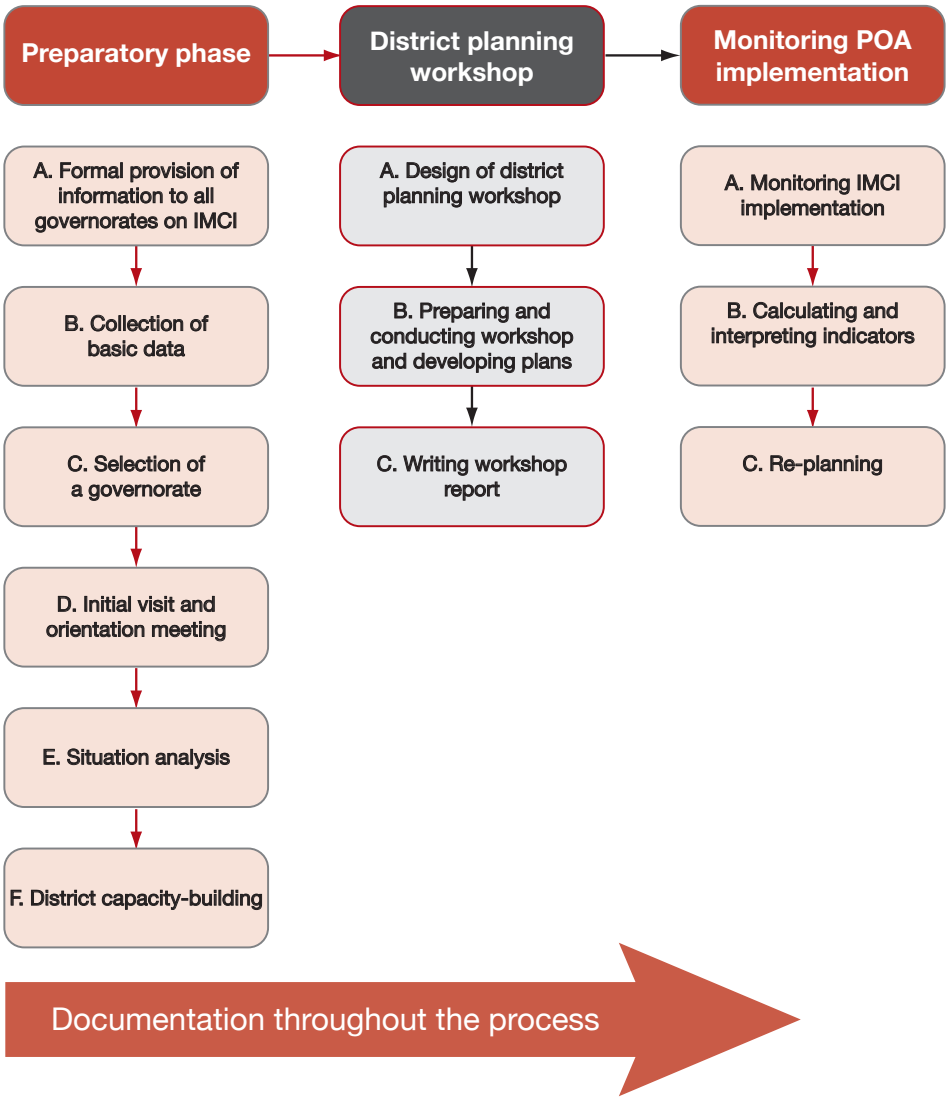


Figure 1. Phases in planning for implementation of IMCI at district level

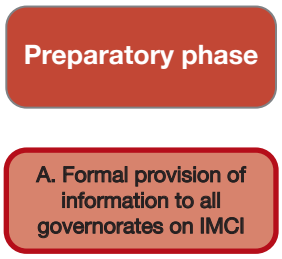
Guide to planning for implementation of

IMCI

at district level

Chapter 2. Preparatory phase

Chapter 2. Preparatory phase

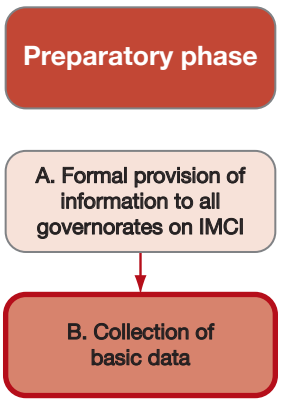


A. Formal provision of information to all governorates on IMCI

Once the IMCI strategy is officially adopted and the national IMCI management structure is officially established in the country, an official circular (an example of which is shown in Annex 1, 1.1) should be sent to all the health directors of all governorates, signed by the Minister of Health, or his deputy. It should:

- inform health officials that IMCI has been adopted as a policy of the Ministry of Health;
- indicate the placement of IMCI within the structure of the Ministry of Health at the central and governorate level;
- explain the phased approach of IMCI implementation among and within the governorates;
- enclose a brief on the IMCI strategy, namely rationale and components (an example of which is attached in Annex 1, 1.2).

This formal information should be followed by national events to orient directors of health in governorates and other stakeholders/partners on IMCI strategy and the progress of implementation in the country.



B. Collection of basic data

In order to select governorates for IMCI implementation according to the selection criteria, the following information needs to be collected early in the process (see Table 1):

- number and names of districts per governorate
- total population in the governorate and by district
- under-5 population in the governorate and by district
- under-5 mortality in the governorate and district (if available). Mapping is preferable[4]
- number and type of health facilities providing child health care services, by district and governorate, including private sector, if relevant
- number of health care providers dealing with under-5 children by district, governorate, and by category[5].

[4] Mapping is the process of presenting under-5 mortality rates by governorate on a map.

[5] This information needs to be updated prior to the district planning workshop in order to take into account any turnover of staff.

Table 1. Key information for selection of governorate for IMCI implementation

Name of governorate:.....

Total population:.....

Total under-5 population:..... Year of estimation: |__|__|__|__|

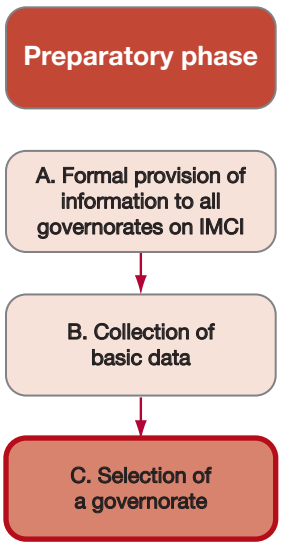
Under-5 mortality rate/1000 live births:..... Year of estimation: |__|__|__|__|

Infant mortality rate/1000 live births:..... Year of estimation: |__|__|__|__|

Number of districts: |__|__|__|__|

Name of the district	Total population	Under-5 population	Under-5 mortality rate per 1000 live births	Number of health facilities providing child care services by type				Number of health care providers who deal with under-5 children at outpatient services (including primary health care, health facility) by category			
				Hospital	Primary health care (PHC)		Other*	Physician	Nurse	Medical assistant	Other**
					Urban	Rural					
District 1											
District 2											
District 3											
District 4											
District 5											
District 6											
District 7											
District 8											
Total											

* Specify other types of health facilities at PHC level such as health posts, etc.
** Specify type of other categories of health care providers.



C. Selection of a governorate

Selection criteria

Although IMCI coverage will be countrywide, implementation will be conducted in a phased manner. During the early implementation phase, regional representation should be taken into account if IMCI will be implemented in more than one area. This would help in advocating for IMCI expansion in different regions by providing evidence that IMCI works in different contexts.

Selection criteria of implementation sites will differ according to the implementation phase. While the selection criteria in the early implementation phase at national and governorate levels would focus mainly on the potential to demonstrate an IMCI implementation model, the expansion phase should address priorities such as under-5 mortality levels and population size. However, the availability of financial and human resources at national and governorate levels will influence the selection of the IMCI implementation area.

Proposed selection criteria for governorates in the early implementation phase

- Committed leadership and staff;
- Previous successful experience in the implementation of other child health-related programmes;
- Easy accessibility: central staff need to travel frequently to implementation areas, in order to assist in planning, conducting activities, monitoring, problem solving, re-planning, etc.;
- Availability of appropriate training sites: identification of suitable sites should be made for clinical training in terms of case load at hospital wards and at outpatient levels, space for theoretical and practical sessions, training equipment and availability of supportive staff. The presence of a medical school and/or teaching hospital will be an asset;
- An accessible referral site for the management of severely sick children, commonly used by first level facilities;
- Presence of partners that would provide extra support for IMCI implementation;
- Presence of a medical school would be an asset.

Proposed selection criteria for governorates during expansion phase

- Under-5 mortality: governorates with relatively high under-5 mortality rates should be identified as high-need areas and be given priority for implementation;
- Under-5 population: relatively densely populated governorates would provide the opportunity to reach more children;

- Governorate size (in terms of number of districts, health facilities and health care providers): in large governorates, it is expected there will be a higher impact, although this requires much effort, resources and time to reach full coverage.

Once a governorate is selected, an official communication should be sent by the central team. This will include the proposed date, time and duration of the initial visit and orientation meeting, the objectives and possible partners to be invited. This will include district health officers (DHOs), heads of maternal and child health (MCH) and primary health care (PHC) units from all districts. A proposed visit schedule will be attached to the communication and will indicate the personnel required for each activity.

Since the IMCI strategy requires a collaborative effort from all concerned child health partners, there is a need to identify partners and major players early on. Raising the awareness of the partners early in the process is crucial to ensure a good understanding of the IMCI strategy, its rationale and requirements for implementation, and will help in soliciting their active contribution.

Potential partners

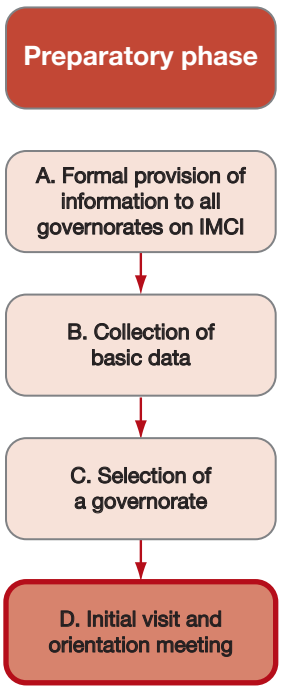
Within the Ministry of Health

- At governorate level: director of health, director of PHC, directors of related programmes including child health programmes, such as control of diarrhoeal diseases (CDD), acute respiratory infections (ARI), nutrition, Expanded Programme on Immunization (EPI), MCH, malaria, HIV/AIDS, pharmaceutical unit, HIS unit, health education unit, community-based initiatives (CBI), curative services department and planning unit[6].
- At district level: district health officer (DHO), head of the MCH/PHC unit, head of district medicine store, the head of the information unit, chief nurse supervisor, director of district hospital, head of paediatric department at district hospital, heads of large health centres[6].

Outside the Ministry of Health

Academic staff of local universities, professional societies and associations (e.g. paediatric society, medical syndicate, etc.), head of health insurance organization office, representatives of existing local government structures, representatives of NGOs active in the area of child health and/or community development, and representatives of international organizations acting in the area[6].

[6] This list covers possible partners. Countries would identify relevant partners according to their Ministry of Health's organizational structure.



D. Initial visit and orientation meeting

Objectives

This is the first visit paid to the selected governorate by the IMCI central team prior to the initiation of any IMCI activities. It takes place over two days (see Annex 2).

The objectives of the visit are to:

- brief the head of the governorate health directorate on the initial visit;
- orient key governorate and district health authorities on the IMCI strategy;
- nominate an IMCI focal person at governorate level according to set criteria;
- select jointly the first district(s) for IMCI implementation;
- train governorate and district teams on tools for data collection from district and health facility levels (situation analysis);
- agree on a schedule of future activities.

These objectives are described below in more detail.

Briefing the head of governorate health directorate

The objectives of this briefing are to:

- emphasize the key points of the official circular sent to all governorates, highlighting the placement of IMCI in Ministry of Health policy and structure (refer to Step A: Formal provision of information to governorates on IMCI);
- discuss and agree on the proposed schedule and activities of the two day-visit, including the participation of the head of the governorate health directorate and other key relevant persons in the orientation meeting (see Annex 2).

Orientation on IMCI strategy

This is the main activity of the visit that brings together all concerned partners from within and outside the Ministry of Health (refer to Step C: Selection of a governorate). Where there is a large number of districts within a governorate with many health staff members, countries might consider conducting several orientation meetings for them prior to the introduction of IMCI, which should be based upon a phased introduction in the governorate. This should be defined according to country situation.

The main aims of this meeting are to:

- inform participants of the official circular related to the adoption of IMCI strategy as part of the Ministry of Health's policy;
- develop a common understanding of the IMCI strategy: the concept, components, rationale and requirements. This includes a description of the three IMCI components, with the aim of highlighting the role of the governorate in each of them; for example, the selection of an IMCI focal point, preparation of a governorate training site for IMCI, and preparation of health facilities;
- discuss the Ministry of Health's policy regarding IMCI implementation: a phased approach, national targets, management structure, criteria set by the country for quality IMCI training and implementation, including selection of districts and staff for training on different skills;
- inform participants on the progress, impact of implementation of IMCI in the country (if implementation has already started in other areas), and main lessons learnt.

A presentation that serves these purposes should be prepared (see CD) that can be adapted according to country situation. The 30-minute presentation should be concise, clear, to the point and without redundancies, so as to keep the interest and attention of the audience throughout. To ensure proper orientation on IMCI, ample time should be allowed for discussions and clarifications after the presentation. A short report highlighting the main points raised during the discussions should be prepared to serve as background during planning.

Nomination of IMCI focal person at governorate level

The central team should agree with the head of the governorate's health directorate on the nomination of an IMCI focal person at the governorate level who:

- holds one of the PHC or child health programme posts at governorate level;
- demonstrates leadership, management skills and has the authority to communicate with district and central teams and other partners, and is a good networker;
- has field experience in managing a similar programme.

In certain countries, particularly in larger districts, an IMCI focal point at district level might be nominated. This could be the health district officer or the head of MCH/PHC unit.

Selection of the district

Selection criteria

After the orientation session, the central team will meet with governorate and district health officials to select the district(s) based on the set selection criteria. If more than one district is to be selected, it is preferable that districts are adjacent to each other, in order to facilitate monitoring, follow-up after training, and supervisory visits.

During the early implementation phase, given the limited experience and capacity for IMCI implementation in the country, it is advisable to implement IMCI in a maximum of two or three governorates, selecting one district each per governorate.

During the expansion phase, it is preferable to select two or more districts per governorate at a time for IMCI implementation, based on the size of the governorate and the districts. This is important in order to minimize disruption of work at health facilities during training, which would entail the temporary absence of staff from many health facilities if only one district is to be selected for IMCI implementation.

As mentioned previously, the selection criteria of districts during the early implementation phase and the initial implementation within a governorate will differ from those used for the expansion phase. These criteria are very similar to the criteria for governorate selection during different phases.

Proposed district selection criteria during early implementation phase

- Committed leadership and staff: this will help in providing a model of IMCI implementation in the early phase;
- Easy accessibility: frequent travel is required by central staff to implementation areas, in order to facilitate assistance in planning, conducting activities, monitoring, problem solving, re-planning, etc.;
- Accessible referral site: it must be capable of managing severely sick children, known to the first level facilities;
- Presence of partners who can provide extra support for IMCI implementation;
- Presence of community structure or volunteers.

Previous successful experience in implementation of other child health-related programmes is preferable.

Proposed district selection criteria during the expansion phase

- Districts with relatively high under-5 and infant mortality rates: they should be identified as high-need areas and be given priority for implementation;
- Relatively densely populated districts with under-5 populations: these will provide an opportunity to reach more children;
- Large districts, in terms of the number of health facilities and health care providers: these require more effort, resources and time to reach full coverage.

Countries may identify additional district selection criteria.

Training governorate and district teams on tools for data collection from district and health facility levels

The central team will train the IMCI coordinator at governorate level and the selected district teams on the different tools for data collection necessary for the situation analysis. This will serve as a basis for the development of the district plan of action during the district planning workshop. Data needed and the methodology of tool use are discussed in Step E: Situation analysis.

Training should also include methods of compilation of different data using the health facility data collection form, according to the compiled table (see Annex 3, Form 3), and conclusions on some items, such as:

- functionality of the referral system, the diarrhoea treatment corner (DTC), and the healthy child clinic, based on the criteria adopted by the country;
- task distribution; reporting on whether there are duplicated or missed tasks;
- adequacy of furniture in the examination room, considering that more than one family member might be accompanying the child;
- minimum requirement for basic equipment and essential medicines; this is also subject to country decision;
- availability of medicines; this refers to the presence of a medicine in the health facility irrespective of quantity, which applies only to the period prior to IMCI implementation and will change according to IMCI set criteria and requirements. The reason for collecting this information prior to IMCI implementation is to know whether or not a specific medicine is a part of the essential medicine and procurement lists.

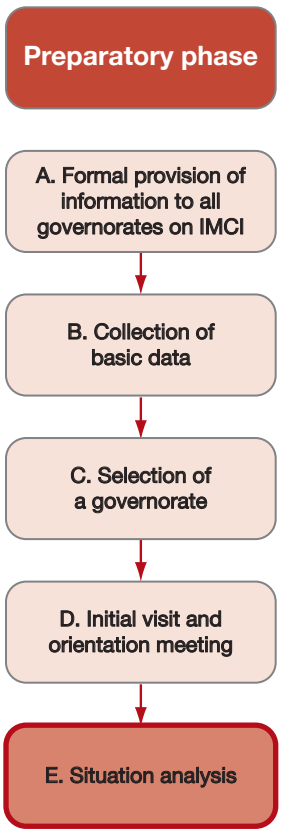
Agreeing on schedule of future activities

By the end of the visit, the central team should agree with the governorate health authorities on tentative dates for the following activities:

- conducting and finalizing district data collection;
- data validation either through meeting of the central team jointly with the governorate and district teams, or through sending collected data to central, and governorate teams for review;

- IMCI district planning workshop that will be organized and conducted (coordinated) by the central team;
- district capacity-building in different IMCI-related skills (case management, facilitation, follow-up and supervision).

These dates should be confirmed by official correspondence from the central team in due time, detailing proposed participants (by position), and proposed schedule of the workshop.



E. Situation analysis

Introduction

A situation analysis is a key step in the process since it forms the basis for sound planning and for measuring the impact of IMCI implementation. It consists of two main activities: data collection and data validation, in addition to other data analysis such as the functionality of the referral system, DTCs, etc. outlined in Step D.

The information collected will serve as baseline data prior to IMCI implementation and is necessary to identify needs for training, for assessing the appropriateness of training sites, as well as the requirements for IMCI implementation at health facilities (medicines, equipment, supervision, health information system, referral, etc.) and other agencies providing health care.

In addition to basic data that is collected centrally prior to the initial visit, more information is needed at two levels: the district and health facility levels. Annex 3 provides examples of tools for data collection at different levels. The suggested items are basic and essential for meeting the objectives of the exercise, and efforts should be made to gather all the information. Some of the data may not be available or may be difficult to obtain in some countries; in this case, they can be skipped (although this should be kept to minimum). This should not apply to essential information.

Activity 1. Data collection

Data collection at district level (see Annex 3, Form 1)

The following data should be collected.

1. Information on population, major under-5 child health problems and under-5 mortality and morbidity, if available. These data will assist in calculating population coverage indicators and in measuring the impact of interventions on under-5 mortality.

2. Infrastructure and human resources. This information will facilitate estimating the district's capacity for IMCI implementation, level of effort needed to implement IMCI, training targets, and requirements for IMCI implementation.

3. Medicines management system.

- Medicines procurement, supply and storage. The administrative level responsible for medicines procurement affects the duration of medicines procurement and consequently its supply to the lower level. The higher the level is, the longer the chain and the time required for medicines delivery. In addition, periodicity of medicine supply to the district and existence of a medicine store at district level will affect the chain of medicine delivery to health facilities. If a medicine store exists at the district level, this will facilitate the medicine distribution process to health facilities in terms of logistics and time. All these factors should be taken into consideration while planning for medicines availability at IMCI implementing health facilities. Periodicity of medicines procurement and supply differ from country to country according to system.
- Essential medicines list and procurement lists. The IMCI adapted clinical guidelines include all medicines needed for the management of common under-5 child health problems. There is a need to check whether those medicines exist on the essential medicines list and the medicines procurement list of the district. This is essential to be able to decide on the means of making those medicines available at the health facilities prior to IMCI implementation.
- Medicine quantification. This process is important to make sure that the medicines are available in sufficient quantities to manage the expected number of under-5 child attendants, with regular supply and no periods of shortages. There are different methods of quantifying medicine needs, including the following.
    - Fixed pre-determined quota. This decision is taken at the level distributing the medicines to the health facility, mostly based on type of facility and irrespective of population served;
    - Population-based: according to the size of population served by the health facility;
    - Consumption-based: according to the quantity of medicines dispensed by the health facility from what was available. This does not imply that what was available was enough to meet the real needs;
    - Caseload-based. This is the most appropriate method and is based on the number of children attending for different morbidities with a marginal additional proportion to cover the possible increase in health service utilization. Ideally, this process should start at health facility level and then the district level calculates the medicine needs for the whole district, compiling the information received from the health facilities. Medicine quantification at district level can also be done based on the information received from individual health facilities related to patients' numbers and proportions of prevailing morbidities;
    - Disease prevalence/incidence-based and number of estimated episodes requiring medicines. This requires conducting regular community surveys to assess morbidity levels of different diseases. Moreover, quantification here targets all outlets of health care, which is not the case in the IMCI plan.
- Medicine distribution to health facilities. Periodicity of distribution differs from country to country, according to available resources, and the existence of stores at both district and health facility levels. In some cases, the system affords some flexibility to health facilities to request or purchase more medicines in case of shortage.
- Supervision on medicine management at health facility level. This includes supervision of quantification of medicines, timely requests, medicine storage, medicine expiry, medicine dispensing, counselling patients on medicine utilization, and maintenance of records and reports on medicine consumption.

4. Existing health information system (HIS). Data guide the work in general, demonstrate the progress, assist in monitoring, planning, problem solving, decision-making, advocacy, etc. Therefore, complete and accurate data are indispensable for successful work. This area, while essential, is not given enough attention. The following information on the health information system is required.

- Existing health information unit at the district health office.
- Existing recording and reporting tools:
  - Reports from health facilities. Every health facility should periodically submit a report on service data to the district. The periodicity of this reporting and its form and content differ from country to country (monthly report, quarterly report, etc.);
  - District data records: in which data sent by all health facilities in the district to the district health office are compiled. These can be manual or computerized. In addition, records exist at the district level for documenting activities carried out by the district office, e.g. record of training coverage in the district;
  - Periodic district reports. These are prepared by the district on data and indicators requested by the higher level (governorate, central, etc). The periodicity, content and form will differ from country to country.
- Data management:
  - Capacity: a) human resources: personnel in charge of information and their level of training on the HIS, e.g. level of skills acquired during training such as data validation, data entry, data analysis and calculation of indicators; b) means of handling data (computerized or manual);
  - Data flow from health facility district to higher level and its periodicity;
  - Processing the data collected at the district level, i.e. data compiled and analysed and indicators calculated and interpreted.
- Whether the available information is used in monitoring progress, documenting achievements, identifying problems and solutions, providing feedback, reporting, advocacy and sound planning.

5. Referral system[7]. Severely sick patients require urgent referral to a specialized and equipped referral facility capable of saving their lives. In addition, a functioning referral system can be a good opportunity for continuing medical education for the staff of the PHC referring facility, through referral feedback and/or direct personal communication between them and the senior staff at the referral facility. The situation analysis includes a description of the current referral system and practices with regard to the following criteria of a functioning referral system.

- Standardized referral guidelines. Some child health programmes (such as CDD, ARI and IMCI) use standardized case management guidelines that clearly indicate conditions which need urgent referral to a designated referral site and the pre-referral management procedures.
- Orientation of staff at referral sites on IMCI guidelines. It is crucial that health staff members at the referral site understand the content of the guidelines used by their colleagues at the referring site. This will accelerate procedures for patient management, and allows for a common language and mutual respect between the two levels.
- Referral notes and registers at referring and referral facilities. A standardized referral note allows for a common language between different levels of health facilities, facilitates the task of filling in forms, and gives more credibility to the health system among patients. It should include, as a minimum, personal data of the patient, major signs identified, preliminary diagnosis and classification of patients, actions taken, the name of the referring facility and health provider, the date and time of referral, and the name of the designated referral site. A standardized register allows for a standardized method of data collection on referral, data analysis and calculation of indicators. It also facilitates the task of filling in the registers by the responsible health staff.
- Known referral site. This should be known to staff at the referring facilities.
- Means of transportation to the referral facility. In some areas, districts provide ambulances to refer severely sick patients from the PHC facilities to the designated referral sites.
- Referral feedback note. This should include, as a minimum, personal data of the patient, name of treating physician and health facility, dates of admission and discharge (if child has been admitted), investigations, final diagnosis, treatment given during the hospital stay, the patient's condition at discharge from the hospital, and follow-up needed by the referring site.

[7] Referral system in this context does not address the care at referral level, although it is an element of the referral system.

- Referral feedback. Data collected from the Region has shown that referral feedback is the weakest component of the referral system in most of the countries. Therefore, gathering information on referral feedback will help planning to strengthen this element of the referral system. For referral feedback to meet its purpose, referral feedback notes should be informative and sent regularly to the health facility. It is important to know how the feedback reaches the health facility. Besides its importance in creating continuity between the referral site staff and staff at the PHC referring sites, referral feedback is also essential in guiding follow-up of patients and can also be helpful as an on-the-job training tool for health facility staff. The mechanism of referral feedback should clearly identify a regular way for timely transmission of referral feedback notes from referral to referring site. This mechanism differs from country to country or even from district to district, according to the existing system, e.g. post, telephone, assigned staff or patient's family.

6. Existing routine supervisory system. Supportive (technical and administrative) supervision is one of the health system's tasks that is of utmost usefulness for reinforcing skills and performance of health care providers, identifying training needs, and identifying and solving problems. The data collected during activity are used for planning purposes. During the data collection, the following items on supervision are to be covered.

- Capacity for supervision: number and type of health cadres involved in routine supervision.
- Plan for routine supervision and periodicity of visits.
- Tools used during supervisory visits, i.e. supervisory (technical and administrative) checklist.
- Methodology:
  - Observation of performance
  - Checking of equipment, supplies and medicines
  - Record review
  - Caretaker interview
  - Feedback
  - Problem-solving.
- Documentation of supervisory visits: health facility register, report writing.
- Use of collected data: calculation and interpretation of indicators and their use for problem identification and solving, for sound planning and monitoring.
- Problems encountered in conduct of routine supervision, e.g. lack of capacity for supervision, problems in keeping planned schedule, unavailability of transportation means, etc.

7. The community component. The IMCI community component is an essential component of IMCI strategy and aims at improving child health-related family and community practices. Implementation of this component will ensure continuum of care between health facilities and homes, which is indispensable for improving child health and reducing morbidity and mortality rates. Planning for this component should go hand-in-hand with the other two components related to health care providers and the health system. Therefore, it would be useful to collect any relevant information that would help in planning for the implementation of this component during the IMCI district planning workshop.

- Brief community description:
  - Literacy rates. The overall literacy rate for a particular district is an important social indicator that can affect child health; of particular importance is female literacy, which has a direct effect on child health-related practices;
  - Socioeconomic status. This has a direct impact on MCH; it plays an important role in shaping child health care practices, such as care-seeking behaviours, and child feeding.
- Environmental sanitary factors. These are important as they have a direct effect on child health. Data here will help identify the community's needs. These will include:
  - Access to potable water supplies and sanitary waste disposal;
  - Existence of polluting and/or hazardous factors.
- Existing local media channels. The media plays a central role in shaping community attitudes and practices. If properly used, it can greatly assist in health promotion. Different forms of media channels

include television, radio, magazines, and newspapers at both national and local levels. Local media are best placed to address the needs of local communities. In this situation analysis, information will be collected on the existing local media channels, including existing cooperation and collaboration with the Ministry of Health at the governorate and district levels.

- Existing community structure. In many districts and communities, there are usually local community structures that may or may not be working in the area of health. However, they are potential resources for improving community health practices. These structures can be nongovernmental organizations, community health workers, local elected councils, youth clubs, women's clubs, religious leaders, parent–teacher associations, etc. It is important to identify existing nongovernmental organizations which have proven to be efficient in supporting the community and have made a positive impact.
- Existing community-based interventions. These can be, for example, health care, education, literacy classes, community development activities, community-based initiatives, etc. Such interventions could be a base upon which the IMCI community component can be built. These interventions might differ from country to country; countries are, therefore, urged to collect data on available interventions and to add them to the data collection tool. It is important to identify the body responsible for those interventions.

Data collection on training site

These data should be gathered by the IMCI coordinator at governorate level on existing and/or potential training sites (see Annex 3, Form 2).

1. Available or potentially available classrooms:
- location (independent or located in a hospital or an urban health centre nearby the hospital);
- number and space of available classes and a room for administrative work;
- existing restroom(s) (toilets).

2. Available or potentially available furniture and audio-visual aids:
- existing available furniture (chairs and tables);
- existing available audio-visual training aids (multimedia, overhead, video and television sets, and flip chart stands).

3. Available facilities for clinical training:
- number of existing available rooms for outpatient sessions (other than the regular clinic), their location and space;
- existing number of paediatric inpatient rooms and beds in the hospital;
- existing neonatal unit or maternal facilities for neonatal clinical training.

4. Caseload over the past 12 months at the potential training sites; hospital outpatient and inpatient departments, neonatal department and the nearby PHC centre.

5. Facilities for lodging non-resident participants and organizing team: existing or potentially available space inside or outside the training sites.

Data collection at health facility level (see Annex 3, Form 3)

1. Type of health facility and population size. The type of health facility could be an MCH unit, urban or rural health centre, polyclinic, etc. It is important to specify the type of health facility to help place IMCI within the system of the health facility. Information on population size is essential for identifying targets and requirements. Finding out the number of health facilities by type and number of health care providers by category working in those health facilities will assist in estimating the volume of work, and training needs for physicians and paramedics. When linked to data on health services utilization, it will also help to calculate the training needs of each health facility so that there is a sufficient number of trained staff who will manage all under-5 children attending the facility.

2. Infrastructure. A properly implemented service requires availability of space. Examination areas need to be appropriate in terms of surface area, illumination, ventilation, and availability of furniture in

relation to the working staff. This information is necessary in order to assess the working environment inside the health facility. It is also important to know whether there is already available space for immunization, a DTC, a healthy child clinic and counselling corner; this will allow for better organization of work and space during the planning for IMCI implementation, aiming at achieving complementarity of services and smoothening patient flow for the population's convenience.

3. Functioning DTC. This is an important service in a health facility as it manages one of the most common child health conditions in the Region: diarrhoea and dehydration. It can help prevent severe degrees of dehydration and its consequences, which include death. In order for it to be functioning properly, the following criteria should be fulfilled.

- Existing space allocated for DTC.
- Trained staff. There should be at least one health staff member responsible for running this corner. She/he should be trained on the national standardized guidelines on diarrhoea case management. The training should be competence-based and done through an in-service training course, or on the job training.
- Available supplies and equipment. These include cups, spoons, water containers to keep the prepared oral rehydration salts (ORS) for daily use at the health facility, graduated measures (for the preparation of large amounts of ORS for use at the health facility), measurement vessels commonly available in the community to be used for ORS preparation demonstrations for mothers, ORS packets, and weighing scales (these can be located anywhere at the health facility and available for use for DTC staff).
- Available comfortable chairs corresponding to the case load of diarrhoea cases at the health facility.
- Table for keeping containers and records.
- Available clean drinking water source at the health facility.
- Maintained register. There should be a register that includes basic data related to diarrhoea classification and management in addition to patient personal data. Information should be collected on the existence of this register and whether it is accurate, complete and up-to-date. It is important to gather information on whether ORS are administered to children in the corner, including the number of children being treated there, either during the visit or as reflected on the register within the last three months. In addition to this, information should be collected on the classifications of dehydration managed at the DTC.
- Available health education material, including demonstration aids.
- Health education sessions at DTC: aside from individual counselling for mothers on each child's condition, it is important to collect data on whether health education sessions on diarrhoea management are conducted regularly at the DTC and their frequency. It is important to know whether there is a schedule and guidelines for those sessions and which topics are addressed. The topics that can be addressed at the corner are:
  - importance of administering ORS
  - ORS preparation
  - quantity to be given according to the dehydration plan
  - managing diarrhoea patients at home
  - feeding/breastfeeding the diarrhoea patient
  - signs that require immediate care-seeking in a child with diarrhoea
  - prevention of diarrhoea.

4. Functioning healthy child clinic (well baby clinics). The aim is to promote care for child health rather than only management of child illnesses, thus promoting child welfare rather than child survival. In this context, the healthy child clinic is an important structure at the health facility. The scope of terms of reference of this clinic differs among countries according to their priorities, resources, availability of written guidelines, etc. In some situations, this clinic might focus on checking immunization status and growth monitoring, while in other situations its scope can be expanded to include feeding/breastfeeding, counselling, developmental screening, stimulation of psychosocial development (care for development), oral hygiene, screening of visual and hearing defects, and screening of other congenital defects.

For a healthy child clinic to be considered as functioning properly, the following criteria should be fulfilled.

- Standardized guidelines: available standardized guidelines that describe the periodicity of clinic visits and components for healthy children in each visit.
- Trained staff: staff should be trained on the standardized guidelines. Training should be competence-based and can be done through an in-service training course, or on-the-job training.
- Adherence of clinic staff to the available standardized guidelines.
- Available supplies and equipment: these include weighing scales, length/height measurement boards, strips for the measurement of head and arm circumference, stethoscope, toys, child files, child cards, vaccination cards, growth charts, equipment for checking visual and hearing defects, pictorial tools for health education, other relevant supplies and health education tools available in the country. These supplies and equipment vary according to countries' systems and policies.
- Child file and clinic register: individual child files should be made for each child attending the clinic; they should include a sheet for the first examination and procedures for the following visits. Information should be collected on the availability of those files and whether they are up-to-date. Registers should include basic data related to care for healthy children. Information should be collected on the existence of this register and whether it is correctly complete and up-to-date.
- Full examination in the first visit: during this visit, a physician should fully examine the child to identify any problem that might require early intervention and special care.
- Defaulters of follow-up should be followed up at home.

  In order to assess the utilization of clinic services, it would be useful to collect information on the compliance of families to the periodicity of the visits as per the national guidelines. Therefore, during the situation analysis, data would be collected on the number of children who complied with this periodicity related to the total number of children who attended the clinic. Collecting this information can be feasible if the register is designed in a similar format as the immunization register, where a child is registered once and followed up, horizontally in the register, for subsequent visits; otherwise it would not be possible to get such information. A random selection of different pages (a minimum number of pages are those which include 100 children) is recommended for this component of data collection, as it can be a time consuming process in clinics with a large number of attendants. In this way, the quality of the recording in the clinic can also be determined.

5. Human resources and distribution of child care responsibilities.

- Number of health care providers dealing with children, by professional category.
- Responsibilities assigned to each health care provider in relation to child management (triage, different tasks of clinical management, oral rehydration therapy (ORT) corner, healthy child clinics, immunization, counselling and health education, recording patient information, filling in monthly reports, dispensing medicines, counselling on medicines). This information is important for estimating training needs and to organize the work and patient flow at the health facility.
- Smooth patient flow. This is the organized path of the patient from entry to exit during the visit to the health facility (according to the flow chart), avoiding bottlenecks and repetitive coming and going within the health facility in order to receive the service.

6. IMCI basic equipment and supplies. Checking the existence and functionality of basic equipment required for child management and the availability of supplies. The list of required basic equipment differs from country to country according to the IMCI adapted clinical guide and terms of reference for health facilities (refer to the generic example in Annex 3, Form 3).

7. Medicine supply management. Countries have different policies on medicine supply and dispensing, such as Ministry of Health system, health insurance system, revolving funds, subsidized or non-subsidized. Planners should be aware of those mechanisms and assist in ensuring availability and affordability of medicines.

- Existing pharmacies or their equivalent. Most health facilities incorporate pharmacies on their premises to store and dispense medicines. However, in some countries, some health facilities, particularly rural ones, keep medicines in a cupboard or in a small corner. Finding out this type of information will help in understanding the capacity of the health facility in storing medicines.

- Medicine storage. Appropriate medicine storage is essential for keeping them safe for patients' use. The appropriate way of storing medicines involves arranging them on shelves, away from humidity, etc. There are many ways of arranging medicines on shelves, for example by pharmacological group or by alphabetical order.
- Medicine management records. There are many types of medicine management records, however each health facility should have at least two records: medicine requests and a medicine inventory book or card. This helps monitoring stock and estimating types and quantities of medicines to be requested. It is important also to observe whether those records are well maintained in terms of updating, complete information and correct recording.
- Medicine quantification and request. It is important to know whether medicine quantification and requests are done at the health facility and on what basis. Knowing the person responsible for this task is important if any capacity-building activities are to be considered in medicine management
- Medicine supply. Information on frequency of medicine supply from the district to the health facility and any time lapse between medicine requests and medicine supplies will help to identify periods of shortage at the health facility level. Information on the possibility of supplying emergency medicines and/or other medicine items outside the medicine supply schedule is also helpful during planning, so as to ensure medicine availability at the health facility at all times.

8. Health information system.

- Individual patient records. Some countries use individual patient files and records where all personal and family medical history is recorded. This might be part of the family medicine system, health insurance system or the ordinary system.
- Registers. The availability of child health care registers and good maintenance of such records are helpful in documenting information. Such documents are the source of information essential for planning and monitoring purposes, at both the health facility level and even the national level. At health facilities in some countries, there are many registers that sometimes contain the same information. This creates large amounts of paper work and unnecessary duplication. In some countries, the information system is computerized.
- Reports. Health facilities usually send reports to districts on agreed upon information by the national level. In most cases, these reports are prepared and sent on a monthly basis to the governorates, then to the national level. Ideally, these reports contain information required to calculate health indicators in order to help monitor the progress and guide the re-planning process at different levels.

9. Referral system. Data should be collected on the following.

- Referral site. Every health facility is attached to a specific referral site, which should be well known to all the staff of the health facility and to the population.
- Referral guidelines. It is important to know whether standardized referral guidelines for children exist and are used by the health facility staff.
- Referral notes and registers. Information should be collected on the existence of standardized referral notes and registers for referral, which should be completed and correctly filled out.
- Means of transportation to the referral facility. In some areas, ambulances are available for the referral of severely sick patients (emergency cases), while public means of transport or private cars are used in other areas. Some communities are organizing and paying for special means of transportation for emergency cases.
- Direct personal communication between referring and referral site staff. It is important to notify the health provider who will receive the referred patient at the referral site on the severity of the case and the pre-referral actions taken. This will help the referral site to deal with the patient better and save time that could be vital for the patient's life. It also creates a friendly atmosphere of work, collaboration and mutual respect for the benefit of the patient and increases the credibility of the health system in the eyes of the community. This could be done by telephone. To increase the efficiency of this communication, it would be useful to strengthen the personal relationships between the referring and referral sites' staff, possibly through meetings, conferences or on-the-job training.

- Referral feedback. It is important to know if the health facility is receiving feedback from the referring site and whether it is regular and informative (see Data collection at district level, 5: referral system).

  For the referral system to be efficient, all these elements should be in place at the health facility level.

10. Health services utilization. This is an important indicator of the quality of service delivered by the health facility, of the health provider's work burden, and it also helps to assess progress of utilization after implementation of the interventions. This covers the following indicators.

- Case load: total number of visits of sick under-5 children to the outpatient clinic of the health facility during the past year. This is useful for assessing the quality of service as it reflects, among other things, caretaker satisfaction. It would serve as a baseline for assessing the progress of health service utilization after IMCI implementation. The general clinic register or child clinic register is the source of information. It can either be one register per health facility or one register per provider.
- Work load: average number of children seen by a health provider per day. This information is useful for assessing the organization of work and task distribution within the health facility. It also helps to indirectly assess the quality of service and identify training needs. This indicator will be calculated and used during the district planning workshop.

Tools for data collection

All the information that is collected should be recorded in special forms for ease of use and reference. Examples of these tools are given in Annex 3 and can be used at country level according to need. Data collected at district and governorate levels will be presented on Forms 1 and 2, health facility data will be collected on Form 3 and compiled in Form 4.

Profile of data collectors

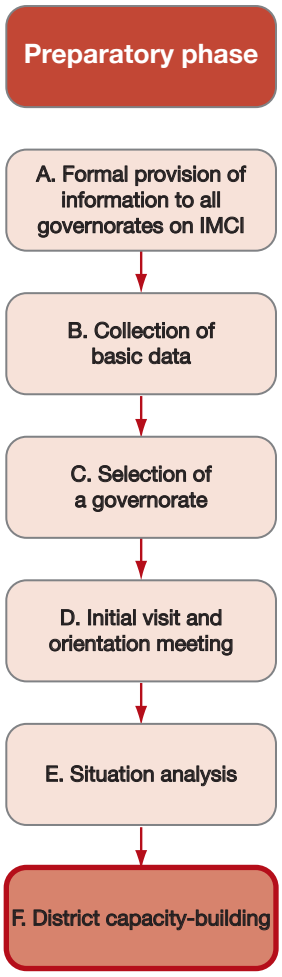
The data collector must personally visit the site and collect information through actual observation. It is preferable to select, from among the district health office team, a data collector who has a technical background, particularly for checking functionality of basic equipment and availability of medicines. She /he could be a doctor, a nurse, a medical assistant, a nutritionist or other appropriate relevant staff.

Activity 2. Validation of collected data

Setting a practical, feasible plan has to be based on objective information about the existing situation, rather than on subjective impressions. As such, the collected data need to be complete, appropriate and consistent. Completeness means that all data required in the forms are filled in, consistency means that data are matching with the data available in other sources and appropriateness means that the intended information is collected. A central IMCI staff member, data collectors and the district health officer should jointly conduct the data review, either through a visit to the district or by sending the data to the central team and district health officer, followed by providing feedback and comments. The involvement of data collectors in this process is important so as to answer any queries. All parts of the form must be filled in, and all data must be collected accurately. This validation should be undertaken prior to the district planning workshop. The following are examples of consistency checks:

- comparing the calculated percentage of the under-5 population in the district collected in Form 1, with the same data available at central or governorate level;
- comparing the number of health facilities by type collected in Form 1 with those included in Form 2, with the data available at the district and governorate levels;
- comparing data collected at the health facility level with that collected at the district level with regard to medicine supply, information and referral systems.

The involvement of district health officers is indispensable as they are responsible for presenting data during the district planning workshop, and are fully involved in the planning and implementation processes.



F. District capacity-building

Building the capacity of governorate and district staff prior to any IMCI implementation is important for a better understanding of the requirements of IMCI implementation. This will help during the district planning workshop, and will help in creating a pool of facilitators and supervisors at the district level. This includes acquisition of:

- case management skills
- facilitation techniques
- follow-up skills
- supervisory skills.

Capacity-building of these staff members is not only aimed at skills acquisition but will also will help them to better understand the complexity of implementation of the IMCI strategy and in strengthening their role in advocating for this strategy. In addition, capacity-building includes possible involvement in organization and facilitation of case management courses, and follow-up and supervisory visits in other governorates and districts. This has the added value of upgrading staff experience, strengthening the central team, and developing a core of facilitators and supervisors in their own districts. These staff members could be the IMCI coordinator at governorate/district levels, senior paediatricians from the hospitals, the child health programme manager and/or PHC manager at governorate/district levels.

Guide to planning for implementation of

IMCI

at district level

Chapter 3. District planning workshop

Chapter 3. District planning workshop

Objectives of the district planning workshop

The second phase of district planning cowmprises preparing for, and conducting, planning workshops. This phase is the core of the planning cycle and entails the activities displayed in Figure 1.

Districts differ in terms of demographic characteristics, child health indicators, existing infrastructure, available resources (human, financial and material), referral systems, supervision and medicine management, staff commitment, etc. Therefore, for IMCI implementation to be successful, realistic and feasible district specific plans based on the situation analysis are essential. As a general principle, IMCI implementation in the selected district(s) should aim to achieve 100% implementation before moving to other districts within the same governorate.

The overall objective of the district planning workshop is to prepare a feasible operational plan for each selected district so as to prepare it for quality IMCI implementation, through active participation of governorate and district health key officials, responsible staff and other concerned partners.

The plan for IMCI implementation at the district level needs to be operational in nature, i.e. objectives and targets identified, activities detailed, roles and responsibilities determined, monitoring procedures and indicators clearly stated and a time schedule set. It also needs to be based on situation analyses; and needs identification. The central team is responsible for guiding the planning workshop at the district level so as to ensure good planning at district level, and consistency with the national plan and targets.

The specific objectives of this workshop are:

- to develop a detailed IMCI implementation plan of action specific to the target district, with full involvement of all concerned authorities and partners, primarily at district level, so as to create ownership and obtain their commitment;
- to identify responsibilities, required resources, and time frame for IMCI implementation so as to enable monitoring and ensure implementation of the set plan; and
- to build the planning capacity of concerned governorate and district health staff, and other partners, by setting an example that could be used by other programmes.

A. Design of the district planning workshop

Designing the workshop

The district planning exercise takes place in the form of a workshop, composed of plenary sessions and group work allowing for an active participatory approach.

There are two main options regarding number of governorates and districts to be targeted by the district planning workshop.

- Involving more than one governorate. In such a situation two or three governorates, preferably adjacent to each other, are involved in order to reduce transportation and accommodation costs and logistics. One or two districts per governorate could be targeted. If the country is in the expansion phase, it is preferable to involve a new governorate with one that has past experience in IMCI implementation, so as to allow for an exchange of experiences. Meanwhile, involving more than one governorate in the workshop will allow for joint training plans to be developed, if the districts have a small number of providers. This would minimize the disruption of work at PHC facilities at the districts during the training period, and would ensure the cost efficiency of training activities by enrolling enough health care providers from a larger number of districts in one course;
- Involving one governorate only. In this case, many districts are targeted at a time. This option can be implemented in:
  - a fully decentralized system, in which case the organization of the workshop and the planning are the main responsibility of the governorates with technical assistance from the central team;
  - remote governorates, so as to reduce the number of central staff monitoring and follow-up visits;
  - governorates with a large number of districts and enough health care providers to be enrolled in one training course with minimal disruption of health services at PHC facilities; this will result in the reduction of training costs, mainly those related to accommodation of non-resident participants.

In any of the above options, the number of districts targeted in the workshop should not exceed six, so as to allocate enough time for monitoring group work by central team members, including good planning and sufficient discussions. It is preferable to select adjacent districts at a time, if possible, to minimize the need for accommodation during the training.

Duration of the workshop

The workshop lasts for four full working days, depending on the number of participating districts.

Facilitators

The workshop is facilitated by a minimum of two central-level staff members, including the national IMCI coordinator/focal point, who will also chair the workshop. This team can be strengthened, if possible, by an experienced IMCI focal point at governorate level, trained staff from other related units such as the pharmaceutical department, health information system, community-based interventions, and other relevant personnel at different levels. Within the context of decentralized systems, the central team can work to build the capacity of governorates' health staff in one or more district planning workshops. In this way, governorate health staff can themselves take the responsibility of conducting those workshops for the remaining districts to accelerate the pace of IMCI implementation. This will take place under the supervision of one central staff member so as to ensure the quality and the respect to standards set for this activity.

The role of the central staff in the district planning workshop should include (to be adapted according to country situation):

- organization of the workshop including:
  - undertaking necessary preparations such as logistics, preparation of all background material;
  - developing the workshop schedule;
  - following up with governorate authorities on the list of participants;
- conducting the workshop:
  - giving the main presentations;
  - facilitating and guiding group work and discussions;
- writing and sharing the report of the workshop.

Participants

Workshop participants should include decision-makers and staff in charge of related responsibilities at governorate and district health offices, representatives of teaching institutions (if they exist), in addition to community representatives. Participants should be designated by position. The following represents an example list of candidates who are considered potential participants. The list of participants can be adapted according to country situation.

- Key officials at the governorate level, e.g.
  - director of health, to obtain high level support and to facilitate immediate decision-making during the workshop;
  - IMCI coordinator, who is the official person responsible for IMCI implementation at governorate level;
  - personnel in charge of child-related health programmes (such as PHC, CDD, ARI, nutrition and MCH), as they share technical responsibility for the different IMCI elements;
  - director of curative care, who is the direct supervisor of hospitals; s/he will have an important role in planning for training, in terms of preparation of training sites and planning for the different components of the referral system;
  - director of the general/district hospital, who can contribute to the preparation of training sites and the referral site;
  - director of pharmaceutical affairs, to contribute to the planning for medicine availability and supply;
  - director of health education and information units.
- Key officials at the district level, e.g.
  - district health officer
  - MCH assistant
  - medicine store pharmacist
  - information specialist
  - health educator
  - nurse supervisor.

  Note. The district team is responsible for preparing health facilities for IMCI implementation, and ensuring high-quality implementation of interventions and high-quality health services delivered by health facilities at the district level.
- From teaching institutions (if they exist): head/senior professor of paediatric and community medicine, to orient participants on IMCI strategy and to establish coordinating mechanisms between teaching institutions and the Ministry of Health so as to accelerate the introduction of IMCI into the teaching curriculum, as well as the possible use of the university teaching hospital as a training site.
- Community representatives: representatives of active NGOs at the governorate/district level, known active community leaders, representatives of local councils, etc. Candidates are usually nominated by the respective district team in consultation with the governorate and central teams.

Structure of the workshop and methodology of work

Structure

The workshop is designed to develop the district's plans in a step-wise manner in working groups for the three IMCI components (see Chapter 1). Additionally, there will be specific group work on developing plans for monitoring and documenting experiences during IMCI implementation. The activities of the workshop will include plenary sessions and working group sessions. The core of the workshop is the group work sessions (see Annex 4).

Participants will be divided into groups according to districts, which will also comprise governorate staff. Group work will be facilitated by members of the central team. If the number of groups is small, and there are enough central team members, a facilitator will be assigned to each group; otherwise, available facilitators circulate among the different groups.

Each day of the workshop will be dedicated to one of the IMCI components; i.e. the first day will focus on human resources development, the second day improving health system support, and the third day improving family and community practices. On the last day, as mentioned above, monitoring and documentation group work will also be held. The expected outcome of each day is the development of a plan of action for every component going through the following planning steps:

- defining the overall target of the IMCI plan of action;
- defining the specific target(s) of each IMCI component;
- identifying needs in light of the situation analysis and the set criteria and standards, in order to achieve the targets;
- developing the plan of action, specifying the activities, responsibilities, source of funds and time frame; the plan should also include the monitoring mechanisms;
- setting the indicators to measure the progress of plan implementation.

WHO has identified the readiness of IMCI health facilities as a condition to start the training of health care providers, in order to ensure that a supportive environment for IMCI implementation is in place for the trained staff. The definition of "readiness" of health facilities should be set by each country according to its situation. This means that planning for the training of staff and planning to improve health system elements are closely interlinked and countries might consider beginning with the planning to improve health system elements (second component) prior to the development of the plans of human resource development (first component). In any case, the same session structure described in this chapter will be retained and only the order of the sessions needs to be adapted.

By the end of the workshop, the district plans of the three IMCI components and plans for monitoring and documentation should be compiled in one district plan. The district plans should be compiled in a single governorate plan of action. All the governorate plans should be reflected in the national plan.

Every group work comprises three steps to be taken in the following order:

- Introductory presentation
- Group work
- Plenary session to discuss the outcome of group work.

Inauguration session

The workshop will start with a plenary session during which the official inauguration of the workshop takes place in the presence of the director of the health directorate in the governorate (or his delegate). The national IMCI coordinator or the head of the central team provides an orientation on the IMCI strategy (see CD). This presentation should include the following main points:

- briefing on IMCI strategy: definition, rationale, objectives, components and progress in the country;
- steps already taken related to introduction of IMCI with participating governorates;
- workshop objectives.

This will be followed by group work. Each group session will be preceded by a short plenary introductory session during which a briefing on the component subject of the group work, the group work mechanism, templates to be used and expected outcomes are presented. Each group work session is followed by a plenary session where the outcomes are presented and discussed.

The workshop will end with a plenary closing session to highlight conclusions and recommendations raised during the workshop of common interest to participating governorate and district staff.

As mentioned above, all group work is composed of three main activities:

- short introductory session in plenary;
- group work;
- presentation and discussion of outcomes of group work in plenary.

Group work 1. Planning for human resources development

This group work will include two group work sessions:

1.1 district group work that will review the situation analysis and identify needs;

1.2 governorate group work that will develop a plan of action for the IMCI first component.

Group work 1.1 Situation analysis and identification of needs (district groups)

Introductory presentation

A presentation will be given by one of the facilitators in the plenary. A model introductory presentation is given on the CD where specific information on the country should be amended as needed. Slides should be amended (or added) as needed according to the instructions given in the slides. In the presentation, the facilitator will: 1) introduce the subject; 2) describe the elements of the IMCI first component; 3) explain the procedures during the district group work.

1. Introduce the subject

- Define the objectives of the group work.
- Define an 'IMCI implementing district' and an 'IMCI implementing health facility'. In the Eastern Mediterranean Region, the definition adopted for an 'IMCI implementing district' is 'a district where all health facilities are implementing IMCI', while an 'IMCI implementing health facility' 'is' 'the health facility where all targeted under-5 children are managed by IMCI trained staff'. Countries are urged to adopt this definition so as to facilitate reporting on the indicators used in the Region and to ensure that a high quality service is provided to all children. However, if the definition adopted by the country is different, this should be added to the presentation.
- Define what the IMCI first component is (i.e. pre-service education, in-service training, including follow-up after training) and list the objectives.

2. Describe the elements of the IMCI first component

- Describe the different IMCI training activities in detail, including quality criteria for training; numbers of participants, facilitators and clinical instructors will differ according to the training policy of a country. In general, a course convenes a minimum of two groups and a maximum of four. Each group comprises 6 to 8 participants with a maximum of 24 participants in a course, in order to maintain a high level of training. Each group should have two facilitators, with a ratio of three to four participants per facilitator, in order to ensure supervised practice and acquisition of skills. A clinical instructor will be running the inpatient sessions; ideally, there should be one clinical instructor for every two groups, in the course (if there are more than two groups, there should be two clinical instructors). A course director will coordinate all the activities of the course. In light of this, there are three alternatives:
  - Alternative 1: If the training policy is to have two groups of participants in every course, there should be:
    - 12–16 participants
    - 4 facilitators
    - 1 clinical instructor
    - 1 course director.
  - Alternative 2: If the training policy is to have three groups of participants in every course, there should be:
    - 18–24 participants
    - 6 facilitators
    - 2 clinical instructors
    - 1 course director.
  - Alternative 3: If the training policy is to have four groups of participants in every course, there should be:
    - a maximum of 24 participants
    - 8 facilitators

- 2 clinical instructors
- 1 course director.

The alternative that matches the country's training policy should be added to the slide and presented to the groups.

- Set the selection criteria of participants for training. The primary targets for training are the health care providers who manage under-5 children at PHC facilities and outpatient departments at the targeted referral facilities. Other health staff might participate in those courses according to needs, such as:
  - IMCI focal points and supervisors at governorate and district levels who are responsible for monitoring IMCI implementation at district level and who are involved in IMCI supervisory visits;
  - paediatricians working at the hospital with good previous experience as trainers, who would serve as potential facilitators and clinical instructors and who can assist in course preparation (if the hospital where they work will be selected as a training site);
  - staff members at medical and paramedical teaching institutions who are committed and preferably have previous experience in teaching public health approaches, such as CDD, ARI and EPI. These would serve as potential future facilitators and clinical instructors and would assist in introducing and implementing IMCI pre-service education.

  All selected participants should be fully available during the whole training period. Those who are working at the PHC unit and the outpatient department at referral facilities should not have other commitments and should have no plans to leave their place of work for at least the coming year. The national training policy should also state whether training is mainly the responsibility of the central IMCI team or the governorate IMCI team.
- Describe the required IMCI training sites. This depends on the training policy in terms of number of classrooms, outpatient department sites and inpatient wards as mentioned above. The ideal situation is to have one site where it is possible to conduct all activities, i.e. theoretical sessions and the two types of clinical sessions. This helps in reducing the time and costs required for transportation. If this is not possible, a trial should be made to have, at least, all clinical sessions, i.e. inpatient and outpatient, at the same site. The theoretical sessions could be located at a different site.

  If the case load in the clinical training site is not sufficient or the working hours of the outpatient department do not allow for clinical training of three to four groups, a nearby additional site is needed. In addition, if there is no nursery at the inpatient clinical training site, a maternity unit is required nearby to allow exposure to sick young infants. The number of rooms required for theoretical sessions is linked to the number of groups enrolled in a course as per the country training policy as mentioned above in the three alternatives. For example, if Alternative 1 reflects the country training policy (i.e. two groups of participants per course) the following are required:
  - Theoretical sessions:
    - two classrooms, one for each group;
    - one room for the secretariat at the same site selected for theoretical sessions;
  - Outpatient sessions:
    - at least 40 sick under-5 children per day;
    - one large hall that can accommodate participants in a group with an equal number of mothers and children, in addition to two facilitators;
    - if this is not available, two halls where the group can be divided into two small subgroups with one facilitator each, also bearing in mind the number of mothers and patients;
  - Inpatient sessions:
    - at least 10 new cases of sick under-5 children admitted every day;
    - a nursery with at least 10 new newborn sick cases every day;
    - one ward with the number of beds equivalent to the number of participants in a group, in addition to one bed for demonstration;
    - if this is not available, two wards where participants can be divided into two subgroups with an equal number of beds.

A checklist of the requirements for a training site is given in Annex 5 (Tool 1).

- Describe the logistics needed for the training.
  - Transportation is needed for facilitators to reach the training site. The clinical instructor needs separate means of transportation as s/he needs to reach the inpatient training site very early in the morning. Transportation might also be needed for non-resident participants to reach the training site. Transportation is needed for the whole group during the clinical sessions if the training site is more than 5 minutes walking distance from the theoretical training site.
  - Accommodation is needed for the non-resident organizing team and participants.
  - As the course is a full day, catering is needed to provide two coffee breaks and one light lunch break.

3. Explain the procedures during the district group work

Before participants start the district group work they should be made fully aware of all the steps, in the following order.

- Review of the current situation related to the IMCI first component in the district.
- Identification of needs based on data from the situation analysis and the set criteria for implementation.

Explain that during group work they will be using special templates to guide them through each step. By the end of the group work, each district should have prepared a presentation on the situation analysis and needs assessment related to the first component according to Forms 5, 6, 7 and 8 (Annex 5).

Group work

The contribution of university staff to group work 1 is essential. Their full involvement in the workshop, if possible, is useful. The facilitator will distribute the following to participants:

- handouts of the introductory presentation
- list of requirements for training sites (Annex 5, Tool 1)
- situation analysis (Annex 5, Forms 5 and 6)
- identification of needs (Annex 5, Form 7)
- template for the group work presentation (either on a CD or a transparency according to the available visual aids). An example template of this presentation is provided on the course CD, which is subject to modification according to the country situation.

The following steps will be followed during the group work.

1. Present the district situation analysis on the IMCI first component

Designated district staff will present the results of the situation analysis related to the first component, and the team will then discuss needs. The following will be presented according to the template on the CD:

- number of health facilities and staff working at each health facility by category and case load;
- training site: location and description according to the items in Tool 1;
- available transportation: if the theory sessions are taking place at a different location other than the clinical sessions, the district team needs to report on the availability of transportation;
- accommodation: possible convenient places to accommodate participants and facilitators who are not resident in the district.

2. Identify needs

The group should refer to the results of the situation analysis related to the list of requirements detailed in Tool 1, as well as the quality criteria included in the handouts of the group work introductory presentation.

- Training site. The group will decide on the suitability of the training site and additional needs according to the results of the situation analysis, Form 5, and the training policy of the country. Usually at the governorate level, there will be only one or two potential training sites that meet the requirements. These might be located in districts other than those participating in the workshop. Therefore, the

above item might not be detailed in the district presentation. In any case, the district focal point should know the selected training site and inform the health care providers targeted for training.

- Number of health staff to be trained.
  - Health staff to be considered for training can be[8]: health care providers who deal with children at the PHC facility and referral level; IMCI focal points; supervisors; academics from medical and allied health professional teaching schools.
  - Selection of personnel to be trained is made according to the training policy of the country. For example, some countries involve only physicians, while others involve physicians and paramedics. In some countries, there are separate courses for every category, and in others different categories are trained on the same course. This should have been clearly explained in the group work introductory presentation, to which the group participants will refer.
  - In order to identify the number of health personnel from each category who need to be trained in order to cover all targeted under-5 children at the health facility, the following situations apply.
    - Situation 1: One or two health care providers working at a health facility. This is the case in many health facilities. Both health care providers need to be trained in IMCI whatever the case load is. This will avoid discontinuation of work in case one of the health care providers is absent. They should attend different courses to avoid disrupting work at the health facility during the training period.
    - Situation 2: A health facility with a large number of health care providers and high case load of patients. Assume, for example, 90 under-5 children and 60 patients from other age groups attending the health facility every day, with eight health care providers working at the health facility and managing both under-5 children and other patients. Assume that the minimum average time to provide a quality clinical examination is 12 minutes per patient, every health care provider will be able to manage five patients in an hour, i.e. 30 patients during 6 working hours per provider. In this situation, the following options are to be considered.
      - Option 1: a decision is made to establish a clinic for under-5 children (who constitute the majority of patients attending the health facility). Three health care providers would cover all children attending the health facility. A fourth should be trained so as to avoid discontinuation of work in case of absence of one of the others, and to cope with the daily changes in case load.
      - Option 2: if all health care providers are dealing with patients from all age categories, and there is no dedicated clinic for children, and with the assumption that in order to provide a quality service a maximum number of 30 patients should be managed per provider per day (12 minutes per patient), five health care providers should be trained to cover the 150 patients, according to the above example. Two additional health care providers should be trained to compensate for the absence of trained staff and to cope with the daily changes in the case load.
  - The existence of additional responsibilities assigned to health care providers, such as administrative work, is an important factor to be considered when deciding on the number of health care providers to be trained. Therefore, the maximum number of health care providers per district in each category that can take a course at any one time, without disruption of work at health facilities, must be identified.
- Transportation. This will be discussed if the training will take place in the district and a new training site will be established. In this case, the group should refer to the handouts of the group work introductory presentation, the specifications of the potential training site and available vehicles to discuss transportation needs for the organizing team and participants.
- Accommodation. This will be discussed if the training will take place in the district. In this case, the group should identify one or more suitable places of accommodation for the non-resident organizing team and participants. These places should be convenient in terms of capacity, standard and prices.

[8] Other categories can be identified according to needs and the situation in the country.

Group presentation

Each district will present results of the situation analysis and identification of needs related to the IMCI first component, according to the presentation template distributed to the groups. The presentation will be followed by discussions for clarifications or corrections. Members of the national team should keep a copy of the districts' identified needs to be appended to the workshop report and for monitoring.

Group work 1.2 Planning for IMCI first component (governorate groups)

Introductory session

After the district presentations, the workshop facilitator will give an introductory presentation in a plenary session. S/he will inform the participants that they will now work in groups according to governorates (i.e. all districts related to a governorate will work in one group), where governorate plans of action will be developed. The reason for this is that the case management training course will involve participants from more than one district. The presentation will focus on: 1) identifying needs at governorate level; 2) describing the planning steps for the IMCI first component; 3) explaining group work procedures.

1. Identify needs at governorate level (Form 8)

- Training needs. Form 8 will be filled in after training needs of all districts have been compiled.
- Training site. Discussion of the need to establish a new training site, or discussion of transportation and accommodation needs if there is an existing training site.
- Pool of facilitators. In most cases, the IMCI central and governorate teams have information on the number of IMCI facilitators at governorate level. This information should be given to the group participants in order to assess the need to increase the governorate pool of facilitators and/or the need for external facilitators.
- Transportation. The group should refer to the results of the district work if a new training site is to be identified. If the governorate staff decide to use an existing training site, the group should discuss transportation needs for the organizing team and participants, particularly if the group will be accommodated in a place outside the training site.
- Accommodation. If needed, one or more suitable places of accommodation for the non-resident organizing team and participants should be identified. These places should be convenient in terms of capacity, standard and prices.

2. Describe the planning steps for the IMCI first component

- Defining the overall target of the IMCI plan.
- Defining the specific target of each IMCI component. This group work will focus on the IMCI first component, which is concerned with the capacity-building of health staff.
- Explaining the planning principle. The plan should be based on the situation analysis conducted in the district, the needs identified during the district group work, standards and specifications set at the national level for basic IMCI implementation functions, and available capacities and resources.
- Developing the plan of action, specifying the activities, responsibilities, source of funds, time frame and indicators. The plan should also include the monitoring mechanisms. Participants will use Form 10, a plan of action for the IMCI first component, prepared especially for this purpose. The template is comprehensive, and includes all items related to planning for including expected dates for accomplishing the task. Activities will be selected according to the situation analysis of a district. For example, if the participants are all from the same district and do not need accommodation, this will obviously not be planned for.
- Setting indicators to monitor the progress of implementation. Examples of indicators related to the IMCI first component are:
    - process indicators reflecting the undertaking of planned activities included in the plan of action, such as the number of audio-visual aids provided, number of participants informed, and the preparation of the training site;
    - output indicators reflecting the direct results of undertaking the planned activities, such as the number of physicians and nurses trained and the proportion of health facilities that have trained health care providers.

By the end, the elements of the template plan of action related to first component will have been explained.

3. Explain group work procedures

The governorate IMCI focal point will be the facilitator of the group work, together with a national IMCI team member. Groups will undertake the following tasks, guided by the identification of needs, prepared by the district groups, and the country IMCI training policy, in addition to the hints on the development of the district operational plan of action (Annex 5, Tool 2):

- identifying targets
- developing a detailed plan of action for the main elements of the first component:
  - preparation of training sites (if needed)
  - planning for IMCI case management training courses
  - planning to increase pool of facilitators (if needed)
  - planning for IMCI follow-up visits.
- preparing group presentation using the plan of action template of the IMCI first component (Form 10).

Group work

The governorate IMCI focal point will be the facilitator of the group work together with a national IMCI team member. They will coordinate the group work to develop the plan of action for the first component, guided by the identification of needs prepared by the district groups, and the country IMCI training policy. During the group work the following forms and documents will be used.

- identification of needs prepared during the district group work
- background on the country training policy (handouts of the introductory presentation for group work 1.1)
- handouts of the introductory presentation
- identification of needs at governorate level (Annex 5, Form 8)
- hints on development of the operational district plan of action (Annex 5, Tool 2)
- costing sheet (Annex 5, Form 9)
- plan of action for IMCI first component (provided on a CD or a transparency according to available audio visual aids). If transparencies are used, paper copies should be provided to prepare the draft plan of action prior to finalization (Annex 5, Form 10).

1. Target identification

The group will start by filling in the first part of the plan of action (Form 10).

- Identifying the overall target of the IMCI implementation plan of action: all health facilities in the district will be implementing the IMCI strategy. This should include the expected dates, by month and year, of achieving set targets.
- Identifying the specific target of the IMCI first component: the number of health care providers by category who will be trained to manage all targeted under-5 children attending the IMCI implementing health facilities, according to the IMCI guidelines, and followed up. This number will be obtained when the group proceeds to the next step.

2. Planning for the IMCI case management training courses

Using Form 8, the group will first determine the needs of the IMCI first component at governorate level, by compiling the identified needs at district level in relation to the following points.

a) Identification of a suitable training site for IMCI courses

- If the governorate will be introducing IMCI for the first time, the group must reach a consensus on the most suitable training site in the governorate, within or outside the participating districts. The results of the situation analysis related to the potential training site already discussed in the group work on situation analysis and identification of needs will help the governorate group to make this decision.
- If the governorate is already implementing IMCI and a suitable training site has been identified and used, the governorate focal point will inform the group about this site, or an additional suitable training site will be identified in one of those districts.

- If a training site is to be established, the group should develop a plan of action to meet the required needs (reference should be made to the identification of needs prepared by the groups and according to the country training policy).
- If an existing training site outside the participating governorates will be used, the group should plan for transportation and accommodation of participants as well as the organizing team.

b) Determining the total number of training courses by category of health care providers

- Compile training needs for the districts based on the needs identified during the district group work (Form 8).
- Determine the total number of health care providers to be trained by category.
- Decide on the number of IMCI case management training courses of providers by category.
- Estimate costs and identify source of funds using the costing tool, if the funding of the courses is done by the government or district budget.

Then the group will continue filling in the plan of action (Form 10).

c) Deciding on course dates

- If the courses are the main responsibility of the central IMCI team, dates will be discussed with the central team members to reach an agreement according to the national plan. The central IMCI team might decide to conduct courses for a specific governorate if there are enough health care providers to be enrolled. If there are not sufficient numbers, courses might be organized for health care providers from two governorates or more according to the situation.
- If the courses are to be conducted by the governorate IMCI teams, they will decide on the dates according to the governorate plan of action. These courses should be monitored by a member from the IMCI central team to ensure their quality (e.g. as a course director).

d) Deciding on participants

- Based on the training needs and the total number of training courses required, determine the number of health care providers who will participate per course (this depends upon whether the courses will only bring together participants from a specific governorate or from more than one).
- Determine the number of health care providers from each district to be trained in each course keeping in mind the need to train the district supervisors in the first course.
- Nominate participants for each course.

e) Notifying participants

This should follow the nomination of participants and should be carried out at least 2 weeks prior to the course. There are different ways to notify participants, the most appropriate of which is an official letter mentioning the purpose of the course, dates, duration, working hours, venue and accommodation for non-resident participants. There should be emphasis on punctuality and commitment to attend the full course and a request for confirmation from participants. Confirmation can also be made either by telephone or during meetings. Since there is the possibility that some health care providers may not be able to attend due to other commitments, the district health team should be ready with a list of alternative possible participants. Names of participants and their places of work should be communicated to the course coordinator.

f) Organization of work during the training period

After receiving confirmation from the nominated health care providers that they will attend the course, the district team should take action to ensure the smooth running of health facilities and aim to avoid disruption of work due to their absence. For example, if there are many health care providers at the health facility, this can be done through internal arrangement by redistributing tasks during the course period; if there is only one health care provider at the health facility, the health care provider at the nearest health facility can replace the course participant while s/he is attending the course.

g) Deciding on facilitators

- Selecting facilitators. The number of facilitators required per course will depend on the training policy of the country. Based on the identification of needs, the group will be aware of the number of facilitators available at the governorate level, and hence a decision on selecting facilitators, from within or outside the governorate, will be made. The plan should also include the need to train more facilitators from within the governorate to widen the governorate pool of facilitators, if needed. This is mainly the responsibility of the governorate and the central teams.
- Notifying facilitators. This should be carried out at an early stage, ideally at least 2 weeks prior to the course, via personal communication. Upon confirmation, this should then be followed by an official letter specifying the dates, venue, as well as accommodation for facilitators coming from outside the governorate.

h) Accommodation arrangements

- Identify a convenient accommodation site.
- Make contact with accommodation site to make appropriate deals. This would include special rates, dates, number of rooms, meals, etc.

i) Conducting the training

- Arrange transportation.
- Provide training materials. The central team should provide the required training materials for course participants, at least one week prior to the course.
- Preparation for the course. every training course is preceded by at least one day to:
  - prepare the training site;
  - make necessary administrative arrangements including catering, payment of participants and facilitators;
  - enable the course director to meet with facilitators to agree on details of the course, according to the protocol of IMCI case management training courses;
  - check training materials and aids are complete.
- Conduct the training courses.

3. Planning for the follow-up after-training visits

- Decide on dates and number of follow-up after-training visits. According to IMCI standards, every trained health provider should receive a follow-up after-training visit 4 to 6 weeks after case management training. The group should decide upon the details.
- Estimate the cost and identify the source of funds (if the funds come from governmental or district budgets).
- Select the follow-up after-training teams. If the governorate is already implementing IMCI it may have a follow-up team and, based on the identification of needs, a decision will be made on the number of follow-up team members needed from within and outside the governorate. If the governorate is just starting IMCI implementation, the plan may include building the governorate follow-up team in addition to selecting follow-up teams from outside the governorate.
- Notify follow-up team members at least 2 weeks prior to the visit, initially through personal communication and, upon confirmation of availability, followed by an official letter mentioning dates, venue and place of accommodation.
- Notify health facilities of the purpose, dates and procedures of the visit and of the need to keep under-5 patients to observe case management. This can be done during the visit of district health staff to health facilities, via a meeting or official communication.
- Arrange official invitation of governorate and district health authorities to attend the governorate/district debriefing meeting. This will include the purpose, date, time and venue of the meeting. The invitation should be made at least one week prior to the meeting. Invitees are the governorate health director, heads of related programmes at governorate level, district health teams, heads of the visited health facilities, and preferably the followed-up providers.

- Arrange transportation for follow-up. This should take into account the number of health facilities to be followed up, the number of supervisors, and the distance between health facilities. It should be planned for on a district basis.
- Conduct the follow-up after training:
  - Check readiness of transportation.
  - Provide follow-up forms. It is the responsibility of the coordinator of the follow-up visit to provide enough forms for observation of the health care providers' performance and assessment of facilities' support for all health facilities targeted by the follow-up visit.
  - Prepare for follow-up visits. Every follow-up visit is preceded by at least one day to: make necessary administrative arrangements including catering, payment of supervisors, etc.; enable the coordinator of the follow-up visit to meet with the IMCI governorate and district focal points to fine tune arrangements; enable the coordinator of the follow-up visit to meet with the supervisors to distribute tasks and responsibilities, assign health facilities and teams, and transport; select a suitable location to conduct the daily work of the supervisory teams after data collection, i.e. data compilation, analysis and preparation of presentations; undertake necessary preparations for the debriefing meeting, including arranging the venue and making sure that the invitations for the meeting have already been taken care of.
  - Conduct the follow-up visit, including the debriefing meeting.

4. Planning for monitoring implementation of IMCI first component plan of action

- Set indicators. The group should refer to the handouts of the introductory presentation of the governorate group work to decide on indicators to monitor the progress in implementing their plan of action. This should be part of the plan as per the template provided (Form 10).
- Identify responsibilities for monitoring the plan of action. For example, the district health officer might be responsible for monitoring activities assigned to the district team; the governorate health authorities will monitor the accomplishment of tasks assigned to the district level; while the central level will monitor the implementation of tasks assigned to the governorate/district teams.

Group presentations

Presentation of the governorate plans of action (see example on the CD) should take place in a plenary session. It should be followed by discussions for clarifications or corrections. The central team should make sure that discussions cover the needs assessment presented previously by the districts. The members of the national team should keep a copy of plans of action.

Group work 2. Situation analysis, identification of needs and planning for elements of health system support

Objective

The second IMCI component concerns the improvement of elements of health system support. It aims to provide a supportive environment for health care providers to enable them to apply the IMCI protocol of child case management and to ensure a good quality of IMCI implementation. Group composition throughout the remaining sessions of the workshop will be similar to that of the district groups on the first day. The group presentations for group work 2 will cover results of the situation analysis, identification of needs, and plans of action of the IMCI second component for each district. The objective of this group work is to develop a plan of action for strengthening the related elements of health system support and preparing health facilities for IMCI implementation, based on the results of the situation analysis and identification of needs.

Introductory session

A model of an introductory presentation, to be given by a facilitator from the central team, is given in the CD. It includes a definition of the IMCI second component and the relevant elements of the health system addressed by this component. Specific information for the country related to this component should be included as needed according to the instructions given in the slides (see CD).

1. Introduce the subject.

a) Objectives of the group work

b) Definition of the IMCI second component

c) Elements of health system support

- Organization of work at health facility. The objective of this element is to improve the following.
  - Task distribution of child care between different categories of health care providers based on their job description. This is to ensure that all child care tasks are covered and not duplicated. It is an important factor for quality service and may require reorganization of space at the health facility and consequently patient flow. For example, the physician is responsible for clinical management of sick children, and the nurse is responsible for taking basic child measurements, counselling and running the DTC. In this case, the examination room should be close to where the nurse is working, either in a counselling area or at the DTC, so as to ensure smooth patient flow.
  - Patient flow. Organization of patient flow shortens the stay of children at the health facility and makes the child's visit more comfortable (this is a main factor of caretaker satisfaction). This will be based on the sequence of steps of child care as per the national protocol (see Tool 3 for examples of patient flow charts). It will also help in distribution of IMCI-related tasks to different OPD staff and strengthen the team concept.
  - Re-organization of space allocated to waiting area, examination room, counselling, DTC, well baby clinic and pharmacy. The waiting area should also be comfortable for caretakers (shaded and protected from draughts), with sufficient seats (the minimum number should be equal to the number of attendants during the heaviest daily case load), and preferably with audio and visual aids to provide health education messages during their stay at the health facility. The examination area should be spacious, well aired with good light and appropriate furniture for the benefit of both the provider and the caretaker. It is mandatory to assign a space for counselling, which has not usually been given sufficient attention, even though it is a main component of IMCI. It is preferable to have a separate room where the health care provider can communicate comfortably with the caretaker. However, if the space does not allow for this, a space for counselling can be made in the DTC, healthy child clinic, or elsewhere.
- Establishing a functioning DTC. The national IMCI team should define the criteria for the functioning DTC (see Chapter 2).
- Establishing a functioning healthy child clinic (see Chapter 2).
- Management of IMCI essential medicines.

  - Medicine availability. The national IMCI guidelines include the list of medicines required for management of sick under-5 children. These should be available throughout the year, therefore quantification of needs should be as accurate as possible. During the group work the teams will be provided with a list of essential medicines adapted according to the national IMCI guidelines (see Form 13) as well as a note to guide the quantification of medicines for different illnesses (see Tool 4).
  - Medicines storage. Proper medicine storage is important to maintain medicine validity. There are several rules for storage, the most important of which is to keep medicines away from humidity, for example on shelves.
- Availability of supplies and equipment. Every country will have a specific list of basic supplies and equipment according to the national IMCI protocol. Participants will be provided with lists of basic equipment required for different service areas, e.g. examination rooms (thermometers, weighing scales, timer, torch lamp, tongue depressor, etc.), immunization (vaccines, disposable syringes, etc.), DTC (ORS, cups, spoons, etc.) and healthy child clinics (see Tools 5–8, subject to adaptation by countries). Based on the results of the situation analysis and identification of needs, groups will be able to develop their plans accordingly.
- Health information system. This includes IMCI recording forms, IMCI register, IMCI monthly report, IMCI follow-up cards, referral notes, DTC register, healthy child clinic register, child files and child cards. These should be available in health facilities in sufficient quantities. The amounts required will be determined during the group work. Discussions should also cover the frequency of reporting (register on daily basis, monthly reports, etc), whether the district/ governorate teams analyse and interpret data, and whether they use those data for re-planning.
- Referral system. The criteria for a functioning referral system (see Chapter 2) should be considered in the development of the plan, including community support for referral such as social support, providing transportation, etc.
- Supportive supervision. This means technical and administrative supervision aimed at strengthening skills and problem-solving in order to improve the quality of health services provided to children. Based on the results of the situation analysis and identification of needs, plans should be developed that include:
- selecting supervisors for training on IMCI supervisory skills
- training of supervisors
- transportation requirements for supervisory visits
- frequency of supervisory visits
- mechanism of monitoring findings of supervisory visits
- availability of templates for supervisory checklists.

2. Plan for the IMCI second component

- Define the target of the IMCI second component: number of health facilities prepared to implement the IMCI strategy by a specific date. Development of the plan of action should include specifying the activities, responsibilities, estimated budget, source of funds, time-frame and indicators. It should also include the monitoring of the implementation of the plan itself. Participants will use Form 15 to develop the plan. Activities will be selected according to the situation analysis of the district in question. The template is comprehensive and includes all items related to planning for the second component. In the district plan of action, activities will be selected according to the situation analysis, as some items will not be applicable to all districts. For example, if districts do not have problems with accommodating health facilities in nongovernmental buildings, this item should not be included in their plan.
- Explain that during planning participants will follow the same planning principles as for group work 1 and the hints on the development of the operational district plan of action (Tool 2).
- Set the indicators to monitor the progress of implementation of the plan. Examples of the indicators related to the second IMCI component are:
  - process indicators reflecting the undertaking of planned activities included in the plan of action, e.g. required medicines provided, number of supervisors trained, examination area relocated, HIS tools provided, etc.

  - output indicators, which are the direct results of undertaking the planned activities, e.g. number of supervisors trained, number of referral site staff oriented, number of health facilities ready to implement IMCI, etc.
- Explain the elements of the plan of action related to the IMCI second component (Form 15).

3. Explain the group work procedures

Before participants start the group work they should be fully aware of the activities to be held, in the following order:

- presentation on the current situation related to the IMCI second component in the district (Form 11);
- discussion of the current situation and identification of needs based on the data of the situation analysis and the set criteria for implementation (Form 12);
- development of district plans of action for the six main elements of the second component, following the same steps as for the IMCI first component (Form 15);
- preparation of a group presentation (see CD): at the end of this group work, every district will present the situation analysis, the identified needs and the plan of action of the IMCI second component in the plenary session.

Group work

The facilitator will provide the following forms and documents that will be reviewed and used by the participants:

- presentation handouts
- results of the situation analysis (Annex 5, Form 11)
- list of essential IMCI medicines (Annex 5, Form 13)
- note on quantification of medicines (Annex 5, Tool 4)
- table to quantify medicines (Annex 5, Form 14)
- identification of needs and plan of action template (Annex 5, Forms 15 and 12)
- distribution of child care tasks among different categories of health care providers in the country, according to central IMCI team
- country model of patient flow (Annex 5, Tool 3)
- lists of IMCI basic supplies and equipment (Annex 5, Tools 5–8)

In addition, Forms 1, 3 and 4 from Annex 3 should be available for the teams.

The following activities will be undertaken during the group work.

1. Presentation of the district situation analysis of the IMCI second component

The designated district staff will present the situation analysis related to the second component. Then the team will discuss the needs according to the situation analysis of the second component (see Form 11 and presentation on CD). The following need to be emphasized during discussion of the health system elements.

- Analysis of the infrastructure: Number of health facilities lodged in government buildings. In some settings, health facilities are housed in rented or temporary sites, which may have implications for continuity of service.
- Essential IMCI medicines: reporting on whether the IMCI essential medicines are part of the essential medicine and medicine procurement lists (see Annex 3, Form 1), and whether those medicines are present at health facilities (see Annex 3, Form 2). In this phase the focus is on the presence of the medicine, and not the quantity.
- Referral system: this information will be obtained from Forms 1 and 2.
- Supportive supervision: this information will be obtained from Form 1.
- Health service utilization: reporting on the total number of sick under-5 children attending the health facilities. This number will be used in the calculation of medicine needs as described in the following section. It will be used also in calculating the average number of visits per child per year, which reflects the degree of health services utilization and community acceptability of the services, by

dividing this figure by the total number of under-5 children in the district. This average should be calculated by the group.

2. Identification of needs

After the presentation, the group should refer to the results of the situation analysis related to the second component, and the forms and handouts distributed to the group in order to identify what is required to prepare health facilities for IMCI implementation (see Form 12; items will be amended accordingly). The following suggestions are made.

- Infrastructure:
  - Examination room. The group should include the need to relocate the examination room or to redistribute some health care providers to another room in their list of identified needs, as appropriate.
  - Furniture. Provision of missing items of furniture (for both providers and caretakers) should be considered among identified needs.

  Note. Needs related to the DTC and healthy child clinic will be addressed under the relevant items below.
- Organization of work at health facility:
  - Patient flow. This should be individualized according to the health facility setting.
  - Basic supplies and equipment. This list should be completed by the national team prior to the workshop according to the list of basic supplies and equipment included in the national IMCI guide.
- Functioning healthy child clinic/well baby clinic. It is worth mentioning that it is not mandatory to print the growth charts separately. What is mandatory, however, is to conduct growth monitoring using a growth chart for each child. Therefore, decision on the need for growth charts should be based on the country policy, whether those charts are included in the child file and used regularly, or in the child card and used regularly or printed separately.
- IMCI essential medicines. The national team should finalize the list prior to the workshop (see Form 13). An accurate quantification of the needs prior to implementation is crucial to improve medicine availability. Tool 4 is a note on quantification of medicines, principles of quantification and detailed methods and examples. The facilitator should work closely with the group to clarify all the items and to help them to calculate correctly the quantities of medicines. Form 14 provides a table for quantification and budget estimation of all medicine items needed. This form needs to be adapted by the national IMCI team prior to the workshop. Quantification of medicines should be done based on the needs of the whole district, except for those few items that are used for severely sick patients at the health facility. These needs are calculated on an annual basis, followed by a calculation on a monthly basis (or otherwise according to the medicine procurement and management policy of the country). The district health staff, in the next phase, should calculate the health facility medicine needs, to be distributed accordingly.
- Health information system. The IMCI recording and reporting tools should be distributed to health facilities. These tools are listed in the model for identification of the needs (Form 12). Quantification of needs is based on the case load at the health facility and the design of the tool. The policy of use of some of those tools is another factor that affects the quantification. For example, in some countries, mothers' cards are distributed for each caretaker, while in others they are used by the health care providers for demonstration purposes only. This section of the table on identified needs should be filled out by all districts.
- Example of HIS tools quantification. If the IMCI register contains 100 sheets, 20 lines each (i.e. data on 20 children per sheet), it will comprise data of 2000 children. If the case load of sick under-5 children in a facility is 1000 per month, this means that this facility needs six registers per year, plus an additional one to cover a possible increase in case load. However, if more than one clinic is examining children at the same time, an additional register for each clinic should be provided.
- The number of IMCI recording forms equals the total case load, 90% of which is allocated to recording forms of children aged 2 months up to 5 years. 10% is allocated to young infants aged 0–2 months. An additional 10% should be added to cope with the possible increase in case load. One

DTC register per facility would be enough per year, plus an additional one to cope with the possible increase in case load. Number of mothers' cards: if distributed to each caretaker, the number of mothers' cards should equal the total case load, plus an additional 10%. If used for demonstration purposes only, 10 per clinic would serve the purpose.

- Functioning referral system. The groups should identify their needs in relation to the six items included in the model for identification of needs (Form 12), namely identification of referral site, referral notes, referral register, orientation of referral site staff, referral feedback note and mechanism for handling referral feedback. The referral feedback is identified as the weakest element of the referral system in most countries. Therefore, emphasis should be placed on this component and district health staff should identify the possible mechanisms according to their context and situation.
- Supervision. The following needs should be identified according to the relevant section of the template for identification of needs:
  - required number of supervisors based on the number of health facilities and agreed upon periodicity of supervisory visits, which will lead to identification of training needs on supervisory skills;
  - provision of supervisory checklist;
  - provision of a template for the supervisory report.

3. Development of plan of action

During this part of the group work, participants will use the plan of action template for the IMCI second component (Form 15). The plan should include specific targets, activities related to all relevant items and indicators for monitoring.

a) Target identification. The overall target of the plan was identified during group work 1. The group will now identify: the specific target of the second component, including the expected dates to achieve the target, by month and year; and the number of health facilities which will be prepared to deliver child health care services according to the IMCI guidelines.

b) Development of plan of action. Planning for the different items related to the second component is straightforward. However, the following points should be considered while developing the plan of action.

- In planning for the health information system, include:
  - identification of flow of information from health facility, to district, to governorate, and central level; this should also include the type of information to be sent and the tools to be used;
  - identification of data processing procedures, such as a review of received facility reports, computer data entry (if available), calculation of indicators, and providing feedback.
- In planning for strengthening the referral system, include:
  - orientation of referral site staff: identification of the event (workshop, seminar, training, meeting) that will orient the staff working at referral level who are responsible for child management on the IMCI strategy guidelines; this will create understanding and a common language between staff at the referring and referral site, and enhance the referral feedback;
  - identification and establishment of referral feedback mechanisms: plan for the channel to send the referral feedback (letters, feedback note, telephone) and the staff who will be responsible for undertaking this function, according to the country situation and system;
  - identification of the referral pathway and catchment area.
- In planning for supportive supervision, include:
  - selection of district supervisors to be trained on IMCI supervisory skills; the selected supervisors should have the skills to conduct the technical component of the supportive supervision;
  - the periodicity of supervisory visits, based on the number of health facilities and supervisors; each supervisory cycle (period during which all health facilities are visited) should not exceed 2 months.

c) Planning for monitoring implementation of the district IMCI plan of action

- Setting indicators. The group should refer to the handouts of the introductory presentation for the district group work to decide on the indicators to monitor the progress in implementing their plan of action. This should be part of the plan (Form 15).
- Identifying responsibilities for monitoring the plan of action as per the template. For example, the district health officer might be responsible for monitoring activities assigned to the district team, the governorate health authorities will monitor the accomplishment of tasks assigned to the district level, while the central level will monitor the implementation of tasks assigned to the governorate and district teams.

Group presentation

There should be a presentation and discussion of the results of the situation analysis and identification of needs and plans of action according to the presentation template distributed to the groups, with reference to the hints on the development of the operational district plan of action. The presentation will be followed by discussions for clarifications or corrections. The central team should make sure that discussions consider the needs assessment presented by the districts. The members of the national team should keep a copy of the presented plans of action.

Group work 3. Planning for the community component

Objective

The third IMCI component mainly concerns the improvement of child health-related key family practices and other child health-related community-based initiatives. The participants will work in their district groups throughout the whole of group work 3. The group presentations will cover results of the situation analysis, identification of needs and plan of action for each district. The objective of this group is to develop plans of action for the preparation of the IMCI community component implementation in the district, based on the discussions and identification of needs during the group work as well as country set priorities and the approach followed by the central team to implement this component.

Introductory session

A model of an introductory presentation, to be given by a facilitator from the central team, is given on the CD. It includes the definition of the third IMCI component, and its elements. Specific information for the country related to this component should be included as needed according to the instructions given in the slides (see CD).

1. Introduce the subject

- Objectives of the group work.
- Definition of the IMCI third component: improvement of child health-related key family and community practices to enable families and communities to play their essential role in caring for children.
- IMCI key family practices: WHO and UNICEF have identified 12 key family practices found to be essential in improving child health. These are:
  - promotion of exclusive breastfeeding
  - improving complementary feeding practices
  - micronutrient supplementation
  - improved hygiene
  - advocating and encouraging immunization against vaccine-preventable diseases
  - prevention of malaria and promotion of use of ITNs (insecticide-treated nets)
  - stimulation of psychosocial development
  - appropriate home care for illness
  - administering antibiotic treatment of infections
  - improving care-seeking behaviour
  - ensuring compliance with health care providers' advice
  - good antenatal care.
- Country priorities. Based on the situation analysis of the key family practices at the national level, every country prioritizes the practices according to the following criteria (ideally a country should select a maximum of three key family practices to address at a time):
  - magnitude of the problem related to the practice
  - impact of the practice on child health
  - potentiality for changing the practice
  - resources required to produce a change
  - presence of existing related experience and/or interventions.

  During the presentation, the IMCI team member will present accordingly the selected priority key family practice(s) and the justification of selection (see CD).
- Progress in the country so far. This slide should summarize the steps undertaken by the national team in relation to the IMCI third component, e.g. organizational structure (national, governorate, etc.), situation analysis of key family practices, priority selection, development of strategies, packages and interventions, selection of governorates for early implementation, implementation status, etc;

- Selection of a community. Criteria for selection are based on the following:
  - functioning IMCI implementation area: where health facilities are implementing IMCI and the trained providers follow the IMCI guidelines in managing children with good counselling sessions, and where they can support the implementation of the community component ensuring linkages between the health system and the community;
  - active, enthusiastic focal person in the community, who is not planning to leave in the near future, who has a good reputation in the community, and preferably good relations with the health facility, and who is willing to do the job; s/he may be health staff or non-health staff, e.g. a community leader);
  - community with high needs: poor child health indicators, socioeconomic status including female educational level, demographic indicators (population size, density), geographic indicators (remote, isolated, difficult access), and environmental and sanitary indicators (accessibility to potable water, sanitary waste disposable, presence of environmental hazards);
  - existing active community interventions/structure/interested partners: this can be an asset to help accelerate the implementation of the child health community-based interventions included in the IMCI community component.

2. Plan for the IMCI third component

The plan of action for this component is different from that of the other two components. While planning the first and second components is usually based on solid information such as number of health facilities and health care providers, etc., issues related to communities require further in-depth analysis. This plan will help health managers at different levels to plan for this analysis and decide on future events. This is because community interventions should be planned with the community and should be tailored to suit the community situation.

- Define the target of the IMCI third component: number of communities in the district prepared to implement the IMCI community component by a specific date (should include the month and year);
- Develop a plan of action to prepare for IMCI community component implementation, specifying the activities, responsibilities, source of funds, time-frame and indicators. The plan should also include the monitoring mechanisms. Participants will use Form 16. For this component, participants should plan for all the items present in the template. It should be made clear that, while planning, they will follow the same planning principles as for group work 1;
- Set the indicators to monitor the progress of implementation of the plan:
  - process indicators, such as: situation analysis conducted, initial visits conducted, orientation workshops conducted, planning workshops conducted;
  - output indicators, such as: communities selected, focal point nominated, plan of action developed, etc;

Explain the elements of the model plan of action related to the third component.

3. Explain the group work procedures

Before participants start the district group work they should be fully aware that the activities differ from the previous two group work sessions. As there is no situation analysis already undertaken at the community level, participants will be unable to identify the needs. Therefore, they will:

- present and discuss the information related to the community component collected at the district level;
- develop the related plans of action according to the template provided in Form 16;
- discuss the tools of the 'community situation analysis,' aiming at collecting further information on the community.
- explain that, at the end of this group work, every district will present in the plenary session.

Group work

During this group work the following forms and documents will be used:

- handouts of the presentation

- templates for the plan of action
- community situation analysis tools.

The facilitator distributes:

- the handouts of the introductory presentation
- the plan of action template for this component (Annex 5, Form 16)
- the community component situation analysis tool (Annex 5, Form 17)
- data collection tool (Form 18)
- the template of the group presentation (see CD).

The following activities will be undertaken during the group work.

1. Presentation of the district situation analysis of the IMCI third component

The designated district staff will present the situation analysis related to the third component using Form 17. This can serve as guidance to the participants to select the communities where they will start data collection based on the criteria mentioned above. Data required to fill in Form 17 can be found on the data collection form for district level (Annex 3, Form 1). The following will be presented to the group:

- communities that do not have access to potable water;
- communities that do not have access to sanitary human waste disposal;
- communities that have polluting factors, such as factories, tanneries, paint workshops, ponds, etc;
- communities that have hazardous factors, such as a high incidence of road accidents, rivers, canals, etc;
- communities that have community structures, such as NGOs, women's clubs, youth clubs, local councils, literacy classes, etc;
- communities that have community-based interventions.

2. Development of plan of action

a) Target identification (see Form 16). The plan should include specific target identification, and planning for all relevant items in the model plan of action. The specific target of this component is the number of communities that will be ready to implement the IMCI community component.

b) Development of plan of action. After the presentation, the facilitator should guide the discussion on the elements of the distributed plan of action and decide on different activities.

- Community selection. This will comprise identification of communities for data collection, guided by situation analysis data and other information available in the district. It is advisable to identify four communities of which two will be selected (see introductory visit below).
- Situation analysis. This comprises:
  - data collection: using the data collection tool (Form 18) the group will discuss all items, identify the staff who will undertake the tasks and identify the dates by which to accomplish this activity;
  - data analysis;
  - sharing data with the central team.
- Introductory visit. A five-day visit to the four communities from which data were collected by the national IMCI community component focal person (possibly with other national IMCI team members), the IMCI governorate focal point and the IMCI district focal point (possibly with other district health staff), and governorate and district teams (this depends on the country policy/strategy of IMCI community component implementation). The objectives of this visit are to:
  - validate the collected information through field visits to the communities, existing interventions, etc;
  - finalize the selection of communities for the IMCI community component implementation;
  - get an idea about opinions of community leaders;
  - get an idea about existing community-based interventions;
  - nominate a focal point in the selected communities;
  - agree on the coming orientation workshop, e.g. date, attendants, place.

- Preparation for the initial visit. This comprises:
  - informing the concerned bodies and persons regarding the dates of the visit and requesting their presence;
  - arranging the transportation;
  - preparing a location to meet with community leaders.
- Activities that will be undertaken during the visit.
  - Visit to the health facility. During this visit, the team will observe the health education session, analyse any existing community-related activity at the health facility (examples from countries include women's clubs, youth clubs and literacy classes). The team will also discuss the knowledge and views of the head of the health facility about the community, its needs, existing community-based structures, and projects. Finally, the team will aim to get an idea about the willingness and readiness of the head of the health facility to be part of the community component implementation. During this discussion the team will be able to judge his/her ability to communicate with the community.
  - Field visits to community-based intervention(s). The team will conduct a quick analysis of the nature of the project(s) and relation to health, mechanism of work, i.e. methodology, structure (staff and channels), resources available (logistics and financial), any available data on its impact, willingness and readiness to collaborate.
  - Meeting with community leaders identified by the governorate and district teams, and posibly those identified through the visit to the health facility and other existing projects. This meeting could be useful to identify the focal point and the volunteers who can be used for community work.
  - The last day will be allocated to discussing the final selection of the community and reviewing the plan of future events.
- Orientation workshop: The objectives are to:
  - brief the participants on the IMCI community component: definition and objectives, selected priority key family practices, and the expected role of attendants;
  - identify readiness of partners to participate in the planned interventions;
  - identify expected role of partners;
  - (possibly) modify interventions;
  - develop a preliminary plan with community representatives.
- Participants in the workshop will comprise: health facility staff, representative(s) of village council, targeted opinion leaders (such as mayors, teachers, imams, priests, influential grandmothers, influential women), decision-makers from different partners (such as NGOs, other projects), etc.
- Preparing the orientation workshop:
  - identification of the participants;
  - identification of the workshop venue;
  - notification of the participants of the dates and venue of the workshop;
  - arranging transportation;
  - preparation of the site (chairs, flip chart, etc.).
- Developing a detailed plan of action. Following the orientation workshop the central team will meet with the governorate and district teams to develop a detailed plan of action for the implementation of the community component. This will be based on the situation analysis, results of an initial field visit and the discussions during the orientation workshop. This plan will include interventions at both the governorate and community levels.

3. Planning for monitoring implementation of the IMCI community component plan of action

- Setting indicators. The group should refer to the handouts of the introductory presentation for the district group work and decide on the indicators to monitor progress in implementing their plan of action.

- Identifying responsibilities for monitoring the plan of action. For example, the district health officer might be responsible for monitoring activities assigned to the district team; the governorate health authorities will monitor the accomplishment of tasks assigned to the district level; and the central level will monitor the implementation of tasks assigned to the governorate/district teams.

Group presentation

This will entail a presentation and discussion of the results of the situation analysis and plans of action (see CD). The presentation will be followed by discussions for clarifications or corrections. The members of the national team should keep a copy of the presented plans of action.

Group work 4. Planning monitoring of IMCI implementation and documentation

This group work addresses the crucial elements of any programme implementation, namely programme monitoring and documentation of progress. Before conducting this group work, facilitators should read Chapter 4 of this document, where monitoring of IMCI implementation and documentation are detailed.

Introductory session

A model of an introductory presentation, to be given by a facilitator can be found on the CD. The main elements of the presentation are as follows.

1. Introduce the subject

- Definition and objectives of monitoring
- Possible mechanisms of monitoring
- Monitoring activities
- Definition of documentation
- Objectives of documentation
- What to document
- Possible tools for documentation

2. Develop monitoring and documentation plan of action

A plan of action (see Annex 5, Form 19) should be filled in by the group.

a) Target identification. Specific targets of this element:

- Monitoring the implementation of all elements of the plan of action and implementation of the IMCI strategy;
- Documenting all events and activities throughout the process.

b) Development of the plan of action. After the presentation, the facilitator should guide the discussion on the elements of the distributed template plan of action.

- Deciding on monitoring mechanisms, such as field visits, desk review of activity reports, monthly reports from IMCI implementing health facilities, etc.
- Deciding on the periodicity of monitoring
- Planning for monitoring
- Deciding on how to report on monitoring
- Assigning responsibilities for monitoring
- Deciding on the mechanisms of documentation
- Assigning responsibilities for documentation
- Identifying mechanisms for dissemination of documents.

c) Setting and calculating indicators. The focus of this section should be on how to calculate the indicators using the available data.

d) Explanation of the elements of the plan of action. Present the plan of action template for these elements and go quickly through them. It is somewhat different than those of the IMCI components. The template is not a complete one and it includes only an example of the activities; its aim is to clarify that all monitoring activities under each component should be included, in addition to other activities related to monitoring the implementation of the IMCI strategy. A section of this template also addresses activities for documentation of the IMCI implementation at the district level.

3. Explain the group work procedures

During this group work, participants will be working in district groups. Referring to the handouts of the introductory presentation of the session, and the plan of action template for this section, the group will be developing the plan of action.

Group work

The facilitator will distribute:

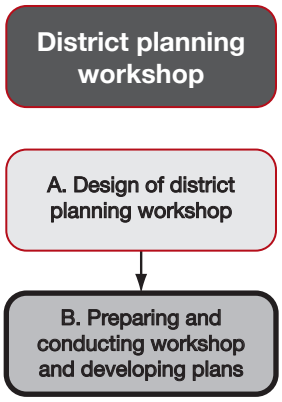
- handouts of the introductory presentation
- plan of action template (see Annex 5, Form 19)
- group presentation template (see CD).

The following activities will be undertaken during the group work:

- developing a list of all activities to be monitored for each IMCI component included in the plans of action and developed by the groups during group work 1, 2 and 3. Monitoring and documentation activities of IMCI implementation at the district level are an essential part of this plan;
- discussing mechanisms appropriate for monitoring each of the activities, as well as identifying the person responsible for the task and its timings;
- identifying the tools for documentation and responsibilities;
- discussing the mechanism and periodicity of report sharing and responsibilities;
- filling in the plan of action template accordingly;
- preparing a group presentation on the plan of action.

Group presentations

This will involve presenting and discussing the plans of action according to the presentation template distributed to the groups. The presentation will be followed by discussions for clarifications or corrections. The members of the national team should keep a copy of the presented plans of action.



B. Preparation and conduct of district planning workshop

Preparation for the workshop

To ensure smooth and successful conduct of the district planning workshop, good preparation is needed at the central level (according to country situation). This process should start early on to allow for adequate communication to take place. Preparation includes the following administrative and technical tasks, guided by the checklists provided (see Forms 20 and 21).

Administrative tasks

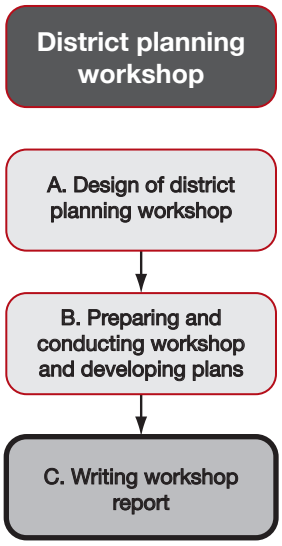
- The national coordinator determines the dates and venue of the workshop in consultation with the governorate health director. This is to ensure his/her availability, participation being crucial to solve problems beyond the capacity of the district health officers.
- The national coordinator determines the numbers and titles of participants from each governorate, according to the list proposed in Chapter 3. Determining the numbers depends on the number of participating districts and the allocated budget. The national coordinator should also consult the governorate coordinator about the proposed community representatives to be invited.
- Reserving the workshop location. This should be done well ahead of the workshop. There must be adequate space for the plenary sessions and at least three other rooms for group work, so as to check the availability of audiovisual aids, power outlets and an adequate number of chairs and tables.
- Sending a formal letter to the governorate health director, indicating the purpose, dates, venue, and participants to be invited from the governorate health directorate, targeted districts and community representatives. The letter should emphasize the participation of the governorate health director and ask him to invite the proposed participants. The invitation of the district health officers should include a request to bring data collected from districts and health facilities and to prepare the presentations on the situation analysis of the three IMCI components at the district and health facilities, using the template sent by the central team (on CD, transparencies or paper).
- Starting formalities to release allocated funds.
- Arranging travel and reserving lodging for facilitators, participants as well as transport of audiovisual equipment, materials of the workshop, and stationery.
- Making sufficient copies of the materials that will be distributed to the participants. These comprise the workshop schedule, handouts of the introductory presentations to the three group work sessions, and forms and tools in the annexes. There should be sufficient for each participant.
- Packing the required materials, audiovisual aids, stationery, flip charts, electrical appliances, etc. (see checklists).
- Catering arrangements.
- Arranging the workshop space. This should be done the day before the workshop and will allow for proper use of space for the groups and the plenary sessions. All supplies and equipment must also be checked.

Technical tasks

- Preparing the workshop schedule. Observing the number of presentations to determine the length of the plenary sessions and size of the assigned tasks for the group work sessions.
- Adapting workshop forms and presentations, such as medicine quantification, etc.
- Designating facilitators for both presentations and facilitation of group work sessions, and assigning the tasks.
- Meeting of facilitators to check tasks are clear and the sequence of topics is logical. They will distribute the tasks so as to avoid duplication or missing items, and will standardize the facilitation process as much as possible.
- Assigning a facilitator as rapporteur. His/her job will be to collect materials presented by district health officers and reporters of the group work sessions, and to write the workshop report.

Conduct of the workshop

Activities of this workshop will be conducted according to the workshop design and structure described under the previous step A. Design of the district planning workshop.



C. Writing the report of the workshop

Prior to conducting the district planning workshop, report writing duties will have been assigned (see B. Preparation and conducting workshop and developing plans). The report should be standardized for the country and, in general, it should comprise the following sections:

- Workshop title
- Dates and venue
- Names of participating governorates and districts
- Objectives of the workshop
- Brief description of the workshop and the proceedings
- Conclusions and recommendations of the workshop
- Annexes: programme, list of participants, group presentations including situation analysis, identification of needs and district plans.

The central team should identify a regular mechanism for circulating the report to the governorates, districts and higher levels.

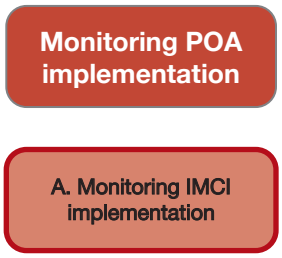
Guide to planning for implementation of

IMCI

at district level

Chapter 4. Monitoring implementation of plans of action

Chapter 4. Monitoring implementation of plans of action



A. Monitoring IMCI implementation

Monitoring is the regular, systematic collection of data on specified indicators of the progress and achievement of objectives and progress, related to the use of funds. It is also a close follow-up of the implementation in order to identify strengths and gaps. Consequently, corrective actions and re-planning will be undertaken. In addition, it aims at strengthening skills and solving problems to improve the quality of implementation. Monitoring should be regularly conducted according to a monitoring plan, following checklists and standards. It monitors the inputs, processes, output, and outcome of a programme's implementation. At district level, it is advisable to focus on inputs and process to monitor implementation of the plan of action.

Steps in programme monitoring include the following.

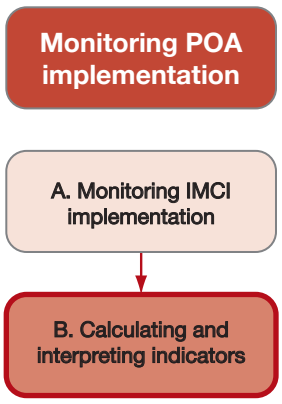
- Gathering information. Monitoring begins with gathering of data on the status of the programme.
- Comparing programme status. The quantitative and qualitative information corresponding to the relevant indicators during the previous steps is compared with those that were planned.
- Determining causes of deviation. Here the emphasis is on finding important reasons for significant differences and causes that are potentially correctable.
- Deciding and taking corrective action. A monitoring and evaluation system serves little purpose if it does not include taking corrective action when needed. No action needs to be taken when deviation is not significant.

Possible mechanisms of monitoring IMCI implementation include the following.

- Communication. This can be verbal, either direct or by telephone, or written e-mail, written correspondence, etc.
- Meetings. These are to follow up the implementation of the plan or implementation of agreed upon corrective actions, etc.
- Desk monitoring of implementation. This will involve reviewing reports sent by health facilities or supervisors to the district health office, such as monthly reports that reflect IMCI implementation at the health facilities, supervisory reports that highlight strengths and gaps in IMCI implementation at health facilities as well as corrective measures taken during supervision. Staff responsible for monitoring should be able to interpret data included in those reports that enable them to evaluate the quality of the service at the health facilities, to extract lessons learnt that might be useful for the future and are helpful to other sites, and to address problems that require higher level intervention.
- Field visits to monitor implementation readiness. These are very important in the early phases as they speed up the preparation process of IMCI implementation, and ensure its quality. This is the basis for the success of IMCI implementation. The visits should be intense and planned regularly and surprise visits. There should also be surprise visits such as the following.
    - Follow-up visits after IMCI training. Follow-up after-training visits to the health facilities take place 4 to 6 weeks after training health care providers in IMCI case management skills. They are meant to solve problems, strengthen skills and document the implementation early in the district. In order to conduct these visits, special training on follow-up skills is required (see Chapter 3, A. Design of the district planning workshop, Group work 1).

- Regular supportive supervisory visits: The supervisory visits are an integral part of the responsibilities of the district health staff. The IMCI programme has upgraded the quality of these visits to become supportive. It comprises two components: a technical part to strengthen the skills of health care providers, and an administrative part to check health facility support and to solve any problems that are encountered. There is a special training course on IMCI supervisory skills (see Chapter 3, A. Design of the district planning workshop, Group work 2). Supervisory skills should be intense at the early stage of IMCI implementation, so as to ensure it runs smoothly and problems can be solved quickly. After this early period implementation should follow the supervision plan according to the schedule.

There are other mechanisms to monitor IMCI implementation such as programme reviews, and surveys. However, these are tasks of the national teams. It is advisable to reflect the plan of action developed during the workshop on a Gantt chart to facilitate monitoring of the plan of action implementation and identify tasks with overlap (see Form 22, Annex 5).



B. Calculating and interpreting indicators

There are many indicators that need to be measured in order to monitor IMCI implementation and its quality in a district. The following are examples.

Under-5 children coverage per facility

- Definition: the proportion of sick under-5 children attending the health facility managed by a trained provider according to the IMCI guide.
- Numerator: number of sick under-5 children managed by a trained provider according to the IMCI guidelines during the past month.
- Denominator: total number of sick under-5 children attending the health facility during the past month.
- Source of information: monthly reports from health facilities and IMCI register.
- Use of indicator. This indicator will tell us to what extent IMCI is being implemented at the health facilities. The IMCI plan is developed with a certain assumption in mind: that all children will be managed by a trained provider. Therefore, if this indicator is less than 100%, the following indicator should be calculated and interpreted to identify the reason behind this problem.

Average daily case load of under-5 children per trained provider

- Definition: number of under-5 children managed by each trained provider per day.
- Numerator: number of sick under-5 children managed by a provider trained on the IMCI guidelines during the past month.
- Denominator: number of providers trained on the IMCI guidelines.

The indicator is calculated as follows:

$$\frac{\text{Number of sick under-5 children managed by a trained provider during past month}}{\text{Number of trained providers x Number of working days in the same month}}$$

- Source of information: monthly reports, district training record.
- Use of the indicator: This indicator will identify the reason behind an under-5 coverage of less than 100%. This may be due to:
  - turnover and nonreplacement of trained staff, and will entail training a replacement and better monitoring of the district training record.
  - high case load versus the number of trained providers. This may be the result of increased health service utilization or poor planning. Analysis of this indicator might entail training of more staff at the health facility to address the high case load.
  - Reluctance of providers to follow the guidelines, as this requires more time to manage each child. It will require identification of the reluctant health care provider(s) to motivate them, and close supervision.

- The indicator can also help to identify the overall training needs at each health facility. It will also give a rough idea of the quality of case management. For example, if the data provided show a large number of children per provider, beyond the estimated number of the programme, one can expect a low service quality.

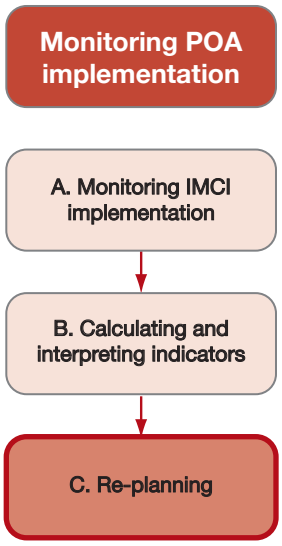
IMCI heath facility coverage

- Definition: proportion of health facilities where all under-5 children are managed by trained providers (i.e. health facilities implementing IMCI according to the regional definition). Countries are urged to adopt this definition, otherwise the definition adopted by the country should be used.
- Numerator: number of health facilities implementing IMCI in the district according to the adopted definition.
- Denominator: total number of health facilities in the district.
- Source of information: under-5 children coverage indicator at each health facility, supervisory and monthly reports.
- Use of the indicator:
  - reporting to the central level on IMCI implementation status in the district
  - reporting on the training needs
  - monitoring progress of IMCI implementation in the district
  - planning for IMCI expansion in the district: whether the team will move to new facilities, or invest in the old facilities to ensure complete coverage.

Health facilities providing quality IMCI services

- Definition: proportion of health facilities where 'essential' IMCI medicines were available all the time during the past month (those medicines should be identified by each country: the minimum list includes pre-referral medicines, first-line antibiotics for pneumonia, first-line antibiotics for dysentery, first-line anti-malarial and ORS) and where health care providers are implementing the IMCI guidelines (e.g. correct assessment, classification and treatment). This is a composite indicator, and is calculated as follows.
- a) As a proportion of the IMCI implementing health facilities:
  - Numerator: number of health facilities in the district where essential IMCI medicines are available and where health care providers are implementing the IMCI guidelines.
  - Denominator: number of IMCI implementing health facilities.
  - Source: follow-up after-training visit reports, supervisory visit reports.
  - Use of the indicator: to assess the quality of IMCI implementation in the district.
- b) As a proportion of the total health facilities:
  - Numerator: number of health facilities in the district where essential IMCI medicines are available and where health care providers are implementing the IMCI guidelines.
  - Denominator: total number of health facilities.
  - Source: follow-up after-training visit reports, supervisory visit reports.
  - Use of the indicator: to assess the quality of IMCI implementation in the district.

The frequency of calculation of this indicator will differ according to the level, i.e. central, governorate or district. At the district level, this might be calculated on a monthly basis. In such a situation, the denominator will be the number of health facilities visited according to the definitions of a) and b). The above serve as examples, and each country should develop its own list of indicators to monitor IMCI implementation and quality.



C. Re-planning

Based on the monitoring results and calculation and interpretation of the indicators, corrective measures should be taken. Modifying the plan of action (re-planning) should be carried out so as to ensure a continuous delivery of high quality services for children, and to fulfil the criteria of IMCI quality implementation. This should be an ongoing process according to needs.

Documentation throughout the process

Documentation

Why?

Documentation provides the institutional memory, recording details of the event and follow-up plans. Therefore, recalling information is not dependent solely upon the individuals involved. Documentation is the process of recording events so as to establish and implement activities of any intervention. It is a cross-cutting activity that should be undertaken throughout the process of IMCI implementation at all levels: central, governorate and district. Each level has its own purpose for and mechanisms of documentation.

For example, the central team should document the IMCI implementation for each governorate, starting from the phase of governorate selection. This could be through workshop reports; minutes of meetings (manual or electronic); reports of training courses; photographs and video film; voice records; follow-up after-training reports; a list of events; a database of training and coverage, etc., so as to provide information at every step. Additionally, documentation can also be used as a reference for every member of the team when a new governorate is to be addressed. Documentation is important to demonstrate the achievement of expected results and targets to the higher level and other partners. One important use of documentation is to advocate for the programme, as it provides evidence of success.

The objectives of documentation are to provide information for:

- keeping the institutional memory;
- identification of resources, needs, planning and decision-making;
- monitoring the progress of plan implementation, identification of gaps and constraints;
- re-planning and taking corrective action;
- evaluating interventions in terms of efficiency, effectiveness and impact, and extracting lessons learned;
- advocating for the intervention using available evidence of success.

What?

The following should be documented:

- steps and activities undertaken to adopt the IMCI strategy in the form of reports, minutes, list of events, etc;
- programme policies, guidelines, quality criteria, work systems in the form of documents, notes, checklists;
- plans of action: targets, indicators, approaches, activities, procedures and steps, in the form of plan of action documents;
- implementation of activities included in the plan of action, such as personnel training, coordination with other organizations and local communities, etc., in the form of activity reports;
- monitoring activities such as documenting results of follow-up of trained providers, supervisory visits in the form of supervisory reports, follow-up reports, monthly reports, etc.

How?

Several tools can be used for documentation at the district level. Examples of such tools are given in Annex 5 (Forms 23 and 24).

- Record of daily events (Form 23): primarily refers to the event title, date, brief description and personnel involved.

- Training record (Form 24): determines which personnel in a certain facility have been trained on what and when. It also records their movements. This record helps to identify staff capacities and facility coverage by IMCI.
- Reports of different activities, such as referral, supervision, community activities, service data, and district level reports on achievement. To facilitate report writing, it is advisable to use a standardized template for each kind of activity. Standardized templates should be provided by the central team.
- Reports of follow-up after training visits.
- Reports of reviews and surveys, if relevant.

Who?

Districts should identify a focal person for documentation. S/he will receive data and reports from different staff that are responsible for conducting activities. This person can be the IMCI focal person at district level and staff of the information centre. While at governorate level, the IMCI focal person should be responsible for this activity. This might differ from country to country according to the situation. The documented information should be shared with the central level so that a consolidated document can be developed. There should be a system at the Ministry of Health to archive the documents in an organized manner and facilitate easy retrieval. This process should be institutionalized and dependent on an individual person. It can be in the form of paper copies, electronic copies, digital copies, etc.

Guide to planning for implementation of IMCI at district level

Annexes

Annex 1. Briefing material for health authorities at the governorate level

1.1 Circular to health directorates at governorate level

Ministry of Health
Minister's Office[1]

Circular to Health Directorates at Governorate Level

The MOH has adopted a new strategy for child health care called 'Integrated Management of Child Health' (IMCI). The strategy is endorsed as part of MOH's policy for primary health care.

The strategy intends to integrate ongoing vertical child health care programmes[2], primarily control of diarrhoeal disease (CDD) and acute respiratory infections (ARI). It focuses on child development and 'quality' health services delivered to children, integrating aspects of child health promotion, disease prevention and standard case management of common childhood diseases. It also emphasizes the role of caretaker, family and community in the area of child health care at the household and community levels. A brief information note on the IMCI strategy rationale and components, is attached[3].

At the central (federal) level, IMCI is hosted by the department of maternal and child health under the primary health care unit. IMCI has to be located under the primary health care unit at the governorate level, and under the maternal and child health sector/unit at the district level[4].

IMCI strategy will be implemented in the whole country in a phased approach, among and within the governorates.

I look forward to your full commitment to, and support for, the implementation of the strategy.

[1] It is preferable that this circular is issued by the minister's office, primary health care undersecretary, or as deemed appropriate by the country, according to organizational structure and procedures. In all cases, the circular should be sent by a high ranking authority within the MOH.

[2] Countries might decide to integrate all child health care programmes under the umbrella of IMCI considered as the primary child health care, or some of them, such as CDD, ARI, nutrition, EPI, growth monitoring, healthy child programme, etc.

[3] Refer to the next page for an example of a brief information note on IMCI rationale, objectives and components.

[4] Countries might differ in placing IMCI according to their own structure, e.g. under PHC, child health unit, MCH, etc.

1.2 Brief on IMCI strategy

1. What is IMCI strategy?

IMCI stands for Integrated Management of Child Health. It is primary child health care at the health facility and at home. It has the following objectives:

- Improving quality of life of children:
  - Promote healthy growth and psycho-social development
  - Reduce morbidity and mortality
- Improving quality of services delivered to children at the health facility and the home

2. IMCI components

First component: improving skills of health care providers

- In-service training:
  - Case management skills of health care providers: a high-quality training course aiming at skills acquisition
  - Facilitation skills: a five-day training course
- Pre-service education: introduction of IMCI into the teaching curriculum of paediatric/community medicine family health departments in medical and paramedical schools
- IMCI follow-up after training

Second component: improving the following health system support

- Availability of IMCI medicines, supplies and equipment included in the IMCI guidelines
- Improving IMCI related HIS
- Improving patient flow and organization of work at the health facility
- Improving supportive supervision (technical and administrative)
- Improving referral system

Third component: improving family and community practices

- Promoting child health key family practices, such as exclusive breastfeeding, complementary feeding, care seeking and home care
- Empowering families and communities to play an active role in caring for the child's health development

3. Rationale for adopting the IMCI strategy

- To promote healthy growth and development of children
- To address common causes of childhood morbidity and mortality
- To improve quality of care delivered to children at both health facility and home through:
  - Improving performance of health care providers (problem-oriented versus holistic approach)
  - Addressing health system problems
  - Improving caretaker knowledge and practices

Annex 2. Proposed schedule of the initial visit and orientation meeting

Day 1:

1 hour	Briefing meeting with the head of the governorate health directorate
3 hours	Orientation meeting
1/2 hour	Meeting with the head of the governorate health directorate to agree on the nomination of the IMCI coordinator/focal point at the governorate level
1 hour	Meeting with key relevant persons to select districts for implementation

Day 2:

3 hours	Training of selected district and governorate teams on using the situation analysis tools
2 hours	Discussion and agreement on future steps

Annex 3. Data collection forms

Form 1. Data collection at district level

Governorate ..... District ..... Date: / /

1. Population

1.1 Population for the year ..... Source of data .....

Total population	
Under-five population	

1.2 What are the main child health problems in the district? .....

1.3 Child health indicators (if available)

Under-five mortality:..... (for the year .....) Source of data .....

Infant mortality:..... (for the year .....) Source of data .....

1.4 Other agencies providing health care to children:

Teaching hospitals [ ] Health insurance [ ] Private sector [ ] NGOs [ ]

Other [ ] specify:.....

2. Infrastructure and human resources

This includes the number of health facilities with OPD/PHC facilities providing health services to under-5 children, by type and number of human resources (by category) (the following table is to be adapted according to the country system).

Health facilities		Number of human resources dealing with under-5 children						
Type	**Number**	**Paediatrician**	**Family health doctor**	**General practitioner**	**Medical assistant**	**Nurse**	**Pharmacist**	**Other (specify)**
General/District hospital*								
PHC urban health facility								
PHC rural health facility								
Other (specify)								

* Other types of hospital might be added if targeted for IMCI implementation (at outpatient department level), e.g. paediatric hospital, fever hospital, university hospital, etc.

3. Medicine management system

3.1 At which administrative level are medicines procured?

Governorate level [ ] District level [ ] Health facility level [ ]

3.2 If the district level is procuring medicines, what is the periodicity of medicine procurement?

Regular [ ] Irregular [ ]

If regular, mention the periodicity:..... months

3.3 How are medicine needs quantified?

Fixed pre-determined quota [ ] Population-based [ ] Consumption-based [ ]

Caseload-based [ ]

3.4 Are all medicine needs procured?

In terms of type: Yes, always [ ] Yes, sometimes [ ] No [ ]

In terms of quantity: Yes, always [ ] Yes, sometimes [ ] No [ ]

3.5 Is there a district medicine store? Yes [ ] No [ ]

3.6 If the governorate level is procuring medicines, what is the periodicity of supplying the district with medicines?

Monthly [ ] Bi-monthly [ ] Quarterly [ ] Semi-annual [ ] Irregular [ ]

3.7 What is the periodicity of supplying health facilities with medicines?

Monthly [ ] Bi-monthly [ ] Quarterly [ ] Irregular [ ]

3.8 Are health facilities allowed to request or purchase medicines in case of shortage in between the supply periods?

Nature of medicines	For hospitals		For PHC facilities	
Emergency	Yes [ ]	No [ ]	Yes [ ]	No [ ]
Other medicines	Yes [ ]	No [ ]	Yes [ ]	No [ ]

3.9 If yes for any: what is the funding source?

Government budget [ ] Treasury fund [ ] Donations [ ]

Other [ ] specify:.....

3.10 Does the medicine procurement list include the following items? Tick the item available:

Item	Present	Item	Present
Amoxicillin syrup (125 mg)		Salbutamol solution	
Amoxicillin syrup (250mg)		Salbutamol syrup	
Amoxicillin tablets (250 mg)		Salbutamol tablets	
Cotrimoxazole suspension		Paracetamol syrup	
Cotrimoxazole paediatric tabs		Iron syrup	
Cotrimoxazole adult tablets		Multivitamin syrup	
Oral rehydration salts sachets		Tetracycline ointment	
Chloramphenicol vials 1 gm		Gentian violet	
Gentamicin amp. 20 mg		Vitamin A capsules 100 000 IU	
Chloroquine tablets		Vitamin A capsules 200 000 IU	
Quinine amps 150 mg/ml		Benzathine penicillin vials	
Quinine amps 300 mg/ml		Erythromycin tablets 250 mg	
Zinc syrup			

Note: This table is just an example. Countries should modify it according to the medicines included in the country IMCI adapted clinical guidelines. Name, form and concentration of the medicines should be included. Different forms and concentrations of the same medicine should be dealt with as separate items

3.11 Is there routine supervision by district level on medicine management at health facility?

Yes [ ] No [ ]

If yes: What is the periodicity of this supervision:..... months

Tick the items covered by this routine supervision:

Quantification of medicines [ ] Timely requests [ ] Medicine storage [ ]

Medicine dispensing [ ] Counselling patients on medicine utilization [ ]

Maintenance of records [ ] Reports on medicine consumption [ ]

Is there a report on each supervisory visit? Yes [ ] No [ ]

How do you use the results of those supervisory visits?.....

4. Existing health information system

4.1 Is there an existing health information unit at the district health office?

Yes [ ] No [ ]

4.2 Are there existing recording tools at district level? Yes [ ] No [ ]

If yes, list those tools: .....

.....

4.3 Are there existing reporting tools?

Reports from health facilities [ ]

Periodicity: Monthly [ ] Quarterly [ ] Semi-annual [ ] Annually [ ]

Reports from district to higher level [ ]

Periodicity: Monthly [ ] Quarterly [ ] Semi-annual [ ] Annually [ ]

Do district reports include reports on child health related programmes? Yes [ ] No [ ]

If yes, list those programmes: .....

.....

4.4 Data management:

Capacity:

How many people are responsible for handling data?.....

Did they receive training on HIS?

All of them [ ] Some [ ] (specify the number)..... None [ ]

Of these, how many were trained in the following (write the number after each item):

Data validation:..... Data entry:..... Data analysis:..... Calculation of indicators:.....

Are the data received from health facilities compiled and analysed? Yes [ ] No [ ]

If yes, what is the system used? Manual [ ] Computerized [ ]

Are indicators calculated? Yes [ ] No [ ]

If yes, list the indicators related to child health:.....

Is the information used? Yes [ ] No [ ]

For what purposes? Monitoring progress [ ] Planning [ ] Problem identification [ ]

Providing feedback [ ] Decision making [ ] Resource allocation [ ]

Advocacy [ ] Other [ ] Specify:.....

5. Existing referral system

5.1 Are there standardized child health-related referral guidelines at the referring site?

Yes [ ] No [ ]

If yes, for which programmes:.....

5.2 Were there orientation meeting(s) on those guidelines to the staff at the referral site?

Yes [ ] No [ ]

5.3 Does the district health officer provide referral notes to the referring facilities?

Yes [ ] No [ ]

5.4 Does the district health officer provide registers to the referring and referral health facilities?

To referring facility: Yes [ ] No [ ]

To referral facility: Yes [ ] No [ ]

5.5 Does the district health officer provide an ambulance for transportation of the referred patients?

Yes [ ] No [ ]

5.6 Does the referral facility provide referral feedback to the referring site?

Yes [ ] No [ ]

5.7 If yes, who manages transmission of feedback notes to the referring facilities?

District health officer [ ] Referral site [ ]

5.8 How are referral feedback notes transmitted to the referring site? (Tick all relevant)

Post [ ] Telephone [ ] Designated staff [ ] Specify:.....

Patient's family [ ] Other [ ] Specify:.....

6. Existing routine supervisory system

6.1 Supervisory capacity: this applies to the existing supervisors who supervise services delivered at PHC facilities among their responsibilities

	Post	Name
1. Physician's supervisors		
2. Nurse's supervisors		
3. Other, specify		
.....		

Tick all relevant answers for the following:

6.2 Is there a supervisory plan? Yes [ ] No [ ]

6.3 Periodicity of routine supervisory visits to each facility: Every week(s) [ ] Every month(s) [ ] None [ ]

6.4 Is there a supervisory checklist for child health related programme? Yes [ ] No [ ]

If no: is there checklist for any other programme? Yes [ ] No [ ]

6.5 If yes, which?.....

6.6 Is the nature of the checklist: Administrative [ ] Technical [ ] Both [ ]

6.7 Methodology of supervision routinely practised:

Observation of performance [ ] Record review [ ]

Checking of equipment, supplies, medicines [ ] Caretaker interview [ ]

6.8 Documentation of the supervisory visit:

Health facility register [ ] Report writing [ ]

6.9 Use of collected supervisory data:

Calculation of indicators [ ] Re-planning [ ] Problem identification [ ]

6.10 Are there problems with the supervisory system? Yes [ ] No [ ]

If yes, what are these problems?.....

7. Information on the community in the district

7.1 Brief description of:

Literacy rate:..... % Literacy rate among females (if possible):..... %

Source of information:.....

Socioeconomic level (tick as appropriate): High [ ] Middle [ ] Low [ ]

7.2 Environmental sanitary factors:

Potable drinking water:

Accessible to all communities [ ]

Partially accessible [ ] Specify communities that don't have access: .....

.....

Inaccessible to all [ ]

Human waste sanitary disposal:

Accessible to all communities within the districts [ ]

Partially accessible [ ] Specify communities that don't have access: .....

.....

Inaccessible to all [ ] Specify communities that have polluting factors (such as factories, painting workshops, ponds, tanneries, etc.): .....

.....

Specify communities that have hazardous factors (such as traffic accidents, river/canals, etc.): .....

.....

7.3 Existing local media channels: Yes [ ] No [ ]

If yes, tick the existing channels: Local TV channels [ ] Local radio channels [ ]

Local magazine or newspapers [ ] Specify: .....

Other [ ] Specify: .....

Is there cooperation between MOH and local media channels? Yes [ ] No [ ]

If yes, describe (at which level, with whom and how):.....

7.4 Existing active community structures: Yes [ ] No [ ]

If yes, tick what is available:

NGOs [ ] Local council [ ] Women's club [ ] Literacy classes [ ]

Youth clubs [ ] Community health workers [ ]

Other [ ] Specify:.....

If NGOs are working in the district, write names of organizations:.....

Are they involved in community-based health-related activities? Yes [ ] No [ ]

If yes, in which health area?.....

Mention other community-based activities they are involved in:.....

7.5 Existing community-based interventions:

Are there any development projects within the district? Yes [ ] No [ ]

If yes, what are they?.....

Who is the responsible body? .....

Form 2. Data on training site

To be filled by the IMCI coordinator at governorate level (for each existing or potential training site, one form should be filled in):

Governorate ..... District .....

A. Available or potentially available classrooms

Location: Within the hospital [ ] Adjacent to the hospital [ ] Distance from the hospital [ ] (.....km)

Availability of classrooms: Number available |__| Number that can be arranged |__|

Size of classes: Class 1:|___ x ___| m Class 2:|___ x ___| m

Class 3: |___ x ___| m Class 4:|___ x ___| m

Availability of a room for administrative work: Yes [ ] Size |___ x ___| m No [ ]

Availability of rest rooms: Two by gender [ ] One shared [ ] No [ ]

B. Available furniture and audiovisual aids (write numbers)

Chairs:	|__|__|	None [ ]
Tables about 2 x 1.2 m (for 10 chairs):	|__|__|	None [ ]
Video sets:	|__|	None [ ]
Television sets:	|__|	None [ ]
Small tables for the TV and video sets:	|__|	None [ ]
Overhead projector:	|__|	None [ ]
Projector screen:	|__|	None [ ]
Multimedia (data show):	|__|	None [ ]
Computer:	|__|	None [ ]
Flip chart stands/writing board:	|__|	None [ ]

Other [ ] specify:.....

C. Available or potentially available clinical training sites

Availability of space for two rooms for outpatient sessions: At hospital [ ] At health centre [ ] No [ ]

Number of paediatric facilities at the hospital: Rooms |__| Beds |__|__|

Number of big rooms (eight beds or more): Rooms |__|

Existing newborn department: Yes [ ] No [ ]

D. Caseload of under-5 children for the last 12 months

Month	At hospital			Nearby primary health care centre
	Inpatient	Newborn unit	Outpatient department	
January				
February				
March				
April				
May				
June				

Total				

Note: Complete the form for the 12 months of the year.

E. Facility for lodging non-resident participants and organizing team

Space for lodging of participants and organizing team: Yes [ ] No [ ]

If yes, specify: Inside the training site [ ] Outside the training site [ ]

Form 3. Data collection at health facility level

Governorate ..... District ..... Health facility .....

Type of health facility: Hospital outpatient department [ ] Polyclinic [ ]
Maternal and child health centre [ ] Urban health centre [ ]
Rural health centre [ ]
Other [ ] specify:.....

Tick as appropriate or write number if asked (for some items you may tick more than one answer)

1. Population in the catchment area:

Population (for the year): |__|__|__|__| Under-five population: |__|__|__||__|__|__|

2. Infrastructure:

2.1 Building: Governmental [ ] Rented [ ] Temporary setting [ ]

2.2 Suitable child examination area (space, illumination and ventilation):
Appropriate [ ] Inappropriate [ ]

2.3 Availability of space for: Immunization [ ] Diarrhoea treatment corner [ ]
Counselling [ ] Healthy child clinic [ ]

2.4 Availability of required furniture: Adequate [ ] Inadequate [ ]

2.5 Appropriate patient waiting space: Appropriate [ ] Inappropriate [ ]

2.6 Functioning diarrhoea treatment corner (DTC):

Is there a DTC at the health facility? Yes [ ] No [ ]

If yes: Who is responsible for this corner? Doctor [ ] Nurse [ ] Nutritionist [ ]

Other [ ] Specify:.....

Are the staff responsible for the DTC trained in standardized diarrhoea management guidelines?

Yes, all [ ] Yes, some [ ] Number of staff trained:..... No one [ ]

Tick all the existing supplies and equipment:

Cups [ ] Spoons [ ] Big container [ ] Graduated measure [ ]

ORS packets [ ] Table [ ] Weighing scale [ ] Chairs [ ]

Measurement vessels commonly used in the community [ ]

Is there a source of clean drinking-water? Yes [ ] No [ ]

Is there an available register? Yes [ ] No [ ]

If yes, is the register (tick all relevant items): Complete [ ] Partially complete [ ]
Up-to-date [ ] Correctly filled [ ]

Types of dehydration classification managed at the diarrhoea treatment corner (tick all relevant items):

Plan A [ ] Plan B [ ] Plan C [ ]

Number of children managed at the DTC over the last month in the register:.....

Do DTC staff conduct diarrhoea management health education sessions? Yes [ ] No [ ]

If yes, is there a notebook on those sessions? Yes [ ] No [ ]

Is there a schedule for those sessions (time and topic)? Yes [ ] No [ ]

Conclude from the above whether the diarrhoea treatment corner is functioning:

Functioning [ ] Not functioning [ ]

2.7 Functioning healthy child clinic:

Is there a healthy child clinic (well baby clinic) at the health facility? Yes [ ] No [ ]

If yes, who is responsible for the clinic? Physician [ ] Nurse [ ] Nutritionist [ ]

Other [ ] specify: .....

Are there standardized guidelines for the care of the healthy child? Yes [ ] No [ ]

If yes, do these guidelines specify periodicity and procedures of the visits? Yes [ ] No [ ]

If yes, specify the periodicity: .....

Are the staff responsible for the clinic trained in those guidelines?

Yes, all [ ] Yes, some [ ] No one [ ]

Tick the components of those guidelines from the following:

Medical check-up upon registration at the clinic [ ]

Feeding assessment (including breastfeeding) [ ]

Feeding counselling (including breastfeeding) [ ]

Regular growth monitoring [ ] Monitoring child development [ ]

Care for development [ ] Checking vaccination status [ ]

Screening of visual defects [ ] Screening of hearing defects [ ]

If there are other components, specify: .....

Tick all existing supplies and equipment:

Weighing scale [ ] Height measure [ ] Length measure [ ]

Strip for arm circumference [ ] Toys [ ] Child files [ ]

Strip for head circumference [ ] Child cards [ ] Stethoscope [ ]

Growth curves [ ] Vaccination cards [ ]

Health education materials [ ] Specify: .....

Equipment for checking visual defects [ ] Specify: .....

Equipment for checking hearing defects [ ] Specify: .....

Other, specify: .....

Is there an individual file for each child attending the health facility? Yes [ ] No [ ]

If yes, does this file include a sheet for the first full examination visit? Yes [ ] No [ ]

Does it include sheets for the following visits? Yes [ ] No [ ]

Is there a clinic register? Yes [ ] No [ ]

If yes, is the register (tick all relevant items): Complete [ ] Partially complete [ ]

Up-to-date [ ] Correctly filled [ ]

Conclude from the above whether the healthy child clinic is functioning: Functioning [ ] Not functioning [ ]

3. Human resources and distribution of child care responsibilities*

3.1 Number of human resources involved in care of under-5 children (i.e., actually working) by category:

Category	Number
Paediatrician	
Paediatric resident	
Family health	
Other specialty	

Category	Number
General practitioner	
Medical assistant	
Pharmacist	
Nurse	

Category	Number
Social worker	
Health educator	
Nutritionist	
Other (specify)	

* These categories can be modified according to the country's system

3.2 Distribution of child care responsibilities:

Is the triage carried out at the health facility? Yes [ ] No [ ]

If yes, specify by whom:.....

Is the sick child's temperature measured? Yes [ ] No [ ]

If yes, who measures the child's temperature?

Doctor [ ] Medical assistant [ ] Nurse [ ] Other [ ] Specify:.....

Is the weight of children attending the health facility measured? Yes [ ] No [ ]

If yes, who measures the child's weight?

Doctor [ ] Medical assistant [ ] Nurse [ ] Other [ ] Specify:.....

Who is in charge of clinical management?

Doctor [ ] Medical assistant [ ] Nurse [ ] Other [ ] Specify:.....

Who counsels caretakers on child feeding?

Doctor [ ] Medical assistant [ ] Nurse [ ] Other [ ] Specify:..... None [ ]

Who dispenses medicines to patients?

Doctor [ ] Nurse [ ] Pharmacist [ ] Other [ ] Specify:.....

Who advises patients on medicines at home?

Doctor [ ] Nurse [ ] Pharmacist [ ] Other [ ] Specify:.....None [ ]

Who is responsible for the oral rehydration therapy corner?

Doctor [ ] Nurse [ ] Medical assistant [ ] Other [ ] Specify:.....None [ ]

Who conducts health education sessions?

Doctor [ ] Nurse [ ] Medical assistant [ ] Other [ ] Specify:.....None [ ]

Who fills in the patient register?

Doctor [ ] Nurse [ ] Medical assistant [ ] Other [ ] Specify:.....None [ ]

Who fills in the monthly report?

Doctor [ ] Nurse [ ] Medical assistant [ ] Other [ ] Specify:.....None [ ]

Conclude by saying whether there is:

Appropriate task distribution [ ] Duplication of tasks [ ] Missing tasks [ ]

3.3 Smoothness of patient flow: Yes [ ] No [ ]

4. IMCI basic equipment and supplies

Write the number of available functioning equipment.

For the supplies, tick if the item is available.

Item	No.	Item		No.
Equipment		**Supplies**		
1. Thermometers		1. DTC supplies	Spoons	
			Cups	
			Container	
2. Child weighing scale		2. Wooden tongue depressor packets		
3. ARI timer		3. Disposable syringes		
4. Nebulizer		4. Mothers' cards		
5. Oxygen source with ancillaries				
6. DTC chairs				
7. Refrigerator for vaccines with thermometer				
8. Vaccine carrier with ice bags				

This list is just an example and should be adapted according to the country's guidelines and needs

5. Medicine supply management

5.1 Is there an existing pharmacy or other equivalent?

Pharmacy [ ] Equivalent [ ] None [ ]

5.2 Is medicine storage appropriate (away from humidity, etc)? Yes [ ] No [ ]

5.3 Are there medicine management records? Yes [ ] No [ ]

If yes, are they: Complete [ ] Updated [ ]

5.4 Who decides on medicine needs (quantification and requests) at the health facility?

Physician [ ] Nurse [ ] Pharmacist [ ] Medical assistant [ ]

Other [ ] Specify:..... No quantification [ ]

5.5 If quantification occurs at the health facility, on what basis are quantities and types of medicines identified in the medicine request?

Caseload [ ] Consumption level [ ] Type of diseases [ ]

Other [ ] Specify:.....

5.6 What is the frequency of medicine supply?

Monthly [ ] Bimonthly [ ] Quarterly [ ] Irregular [ ]

5.7 What is the time lapse between medicine request and medicine supply?..... days

5.8 Are emergency medicines, if needed, supplied outside this schedule? Yes [ ] No [ ]

5.9 Tick the existing essential IMCI medicines in the following table.

Item	Existing	Item	Existing
Amoxicillin syrup 125 mg		Salbutamol solution	
Amoxicillin syrup 250mg		Salbutamol syrup	
Amoxicillin tablets 250 mg		Salbutamol tablets	
Cotrimoxazole suspension		Paracetamol syrup	
Cotrimoxazole paediatric tabs		Iron syrup	
Cotrimoxazole adult tablets		Multivitamin syrup	
Oral rehydration salts sachets		Tetracycline ointment	
Chloramphenicol vials 1 g		Gentian violet	
Gentamicin amp 20 mg		Vitamin A capsules 100 000 IU	
Chloroquine tablets		Vitamin A capsules 200 000 IU	
Quinine amps 150 mg/ml		Benzathine penicillin vials	
Quinine amps 300 mg/ml		Erythromycin tablets 250 mg	
Zinc syrup			

Note: This table is an example. Countries should modify it according to the medicines included in the country IMCI adapted clinical guidelines. Name, form and concentration of the medicines should be included. Different forms and concentrations of the same medicine should be dealt with as separate items

6. Health information system

6.1 Are there individual patient records? Yes [ ] No [ ]

6.2 Are the following registers available (tick if available)? Outpatient register for sick children [ ]

Healthy child register [ ] CDD register [ ] ARI register [ ]

6.3 Quality of recording: Updated [ ] Complete [ ] Poor [ ]

6.4 Are reports regularly sent to the district level? Yes [ ] No [ ]

If yes, how frequent? Monthly [ ] Quarterly [ ]

6.5 Tick the reported child health-related information:

Number of sick children attending the health facility [ ] source:.....

Number of healthy children attending healthy child clinic [ ] source:.....

Classifications/ diagnoses of different child illnesses [ ] source:.....

Antibiotics dispensed to sick children [ ] source:.....

Number of referred children [ ] source:.....

7. Referral system

7.1 Is the referral site well known to the health staff? Yes [ ] No [ ]

7.2 Are there standardized referral guidelines for children? Yes [ ] No [ ]

If yes, which:.....

7.3 Is there a standard referral note? Yes [ ] No [ ]

7.4 Is there a referral register? Yes [ ] No [ ]

7.5 What are the most common means of transportation to the referral facility?

Health facility ambulance [ ] District ambulance [ ] Public means [ ]

Private means [ ] Means supported by community [ ]

7.6 Is there any personal telephone communication between health staff at referring site and those at referral site?

Yes [ ] No [ ]

7.7 Is there feedback from the referral site? Yes, regular [ ] Yes, irregular [ ] None [ ]

If yes, What is the type of feedback? Informative [ ] Very general [ ]

How is feedback handled? By post [ ] By telephone [ ] With the patient/guardian [ ]

With a staff liaison [ ] Not determined [ ]

7.8 Conclude, using from the above information, whether the referral system is functioning:

Functioning [ ] Not functioning [ ]

8. Supervision

Date of last supervisory visit:.....

Did this supervisory visit include observation of performance: Yes [ ] No [ ]

Report of supervisory visit left at health facility: Yes [ ] No [ ]

9. Health service utilization

Total number of sick under-5 children who visited the outpatient department during the last year:..... children

Form 4. Health facility data compilation (sample)

Tick if the item is appropriate/available, or write number if required. For the items that fall in the 'other' category, write down your findings on a separate sheet

Health facility name							Total
Health facility type							
1. Population							
1.1 Total							
1.2 Under-five							
2. Infrastructure							
2.1 Building: governmental							
2.2 Suitable exam area							
2.3 Space available for immunization							
2.4 Diarrhoea treatment corner (DTC)							
Existence of DTC							
All DTC staff trained							
DTC supplies and equipment available	Cups						
	Spoons						
	Container						
	Community vessel						
	ORS packets						
	Weighing scale						
Dehydration managed	Plan A						
	Plan B						
Register complete, updated							
Staff conduct health education sessions							
Conclusion: DTC is functioning							
2.5 Healthy child clinic		Countries adapt and complete the list according to the guidelines					
Healthy child clinic exists							
Standardized guidelines exist							
Supplies and equipment							
Weighing scale							
Height measure							
Head circumference strip							
Stethoscope							
Toys							
Child vaccination cards							
Growth curves							
Clinic register complete, updated							
Conclusion: Clinic is functioning							
2.6 Counselling area							
Counselling area exists	Separate						
	At DTC						
	At healthy child clinic						
2.7 Furniture appropriate							
2.8 Appropriate waiting space							

Health facility name							Total
Health facility type							
3. Human resources							
3.1 Number of staff							
Paediatricians							
Paediatric residents							
Family health doctors							
General practitioners							
Medical assistants							
Pharmacists							
Nurses							
Nutritionists							
Health educators							
Social workers							
Other specialty (nominate)							
3.2 Child care tasks distribution							
Nurses carry out triage							
Temperature measured for every child							
Responsible for temperature measurement	Doctor						
	Assistant						
	Nurse						
Weight measured for every child attending the facility							
Responsible for weight measurement	Doctor						
	Assistant						
	Nurse						
Clinical management	Doctor						
	Assistant						
	Nurse						
Counselling caretakers	Doctor						
	Assistant						
	Nurse						
Dispensing drugs	Doctor						
	Pharmacist						
	Nurse						
Advising on drugs at home	Doctor						
	Pharmacist						
	Nurse						
Responsible for DTC	Doctor						
	Assistant						
	Nurse						
	Nutritionist						
Health education sessions	Doctor						
	Assistant						
	Nurse						
	Nutritionist						
3.3 Smooth patient flow							

Health facility name							Total
Health facility type							
4. Basic equipment and supplies (write down numbers)							
4.1 Equipment							
1. Thermometer							
2. Child weighing scales							
3. ARI timer							
4. Nebulizer							
5. Oxygen source							
6. DTC chairs							
7. Refrigerator for vaccines with thermometer							
8. Vaccine carrier and ice bags							
4.2 Basic supplies* (tick if enough)							
1. Wooden tongue depressor							
2. Disposable syringes							
3. Mother's card							
5. Medicine supply management							
5.1 Existing pharmacy							
5.2 Storage appropriate							
5.3 Deciding on drug needs	Doctor						
	Nurse						
	Pharmacist						
	Assistant						
6. Medicine supply management (cont.)							
6.1 Basis of medicine quantification	Caseload						
	Consumption						
	Disease type						
6.2 Periodicity of medicine supply	Periodic						
	Not defined						
6.3 Number of days between request and supply							
6.4 Emergency medicines supplied outside schedule							
6.5 Availability of IMCI medicines		Countries complete the list according to their adaptation					
Amoxicillin suspension 125 mg, 80 ml							
Amoxicillin suspension 250 mg, 80 ml							
Cotrimoxazole suspension							
Cotrimoxazole paediatric tab.							
7. Information system							
7.1 Available registers	Outpatient						
	Healthy child						
	CDD						
	ARI						
7.2 Updated complete records							
7.3 Reports regularly sent to districts							

* Supplies for DTC and healthy child clinic have been already listed under the specific items to judge the functionality of those two services

Health facility name							Total
Health facility type							
Periodicity	Monthly						
	Quarterly						
7.4 Reports include information on:	Sick child caseload						
	Healthy child caseload						
	Classifications/ diagnosis						
	Antibiotics dispensed						
	No. of referred children						
8. Referral							
8.1 Referral site known to staff							
8.2 Standardized guidelines followed							
8.3 Standard referral note exists							
8.4 Referral register exists							
8.5 Formal means of transportation							
8.6 Referral feedback regular and informative							
8.7 Formal feedback handling mechanism							
Conclusion: Referral system is functioning							
9. Supervision							
9.1 Supervisory visit during the last 3 months							
9.2 Technical supervisory visits							
9.3 Supervisory report left at the health facility							
10. Health service utilization							
Number of under-5 children who visited outpatient department last year							

Annex 4. Proposed programme of the district planning workshop

Day 1

08:00 – 08:30 Registration
08:30 – 10:00 Inauguration session
Welcome address
Presentation by the national IMCI coordinator/senior member of the central team
- Orientation on IMCI strategy
- Workshop objectives

Introduction of participants and adoption of the programme
Coffee break
10:00 – 10:30 Introductory presentation of Group work 1.1: district group work
- Introduction of the subject
- Description of the different elements of IMCI first component
- Explanation of the procedures during group work

10:30 – 12:00 Group work 1.1: district group work
12:00 – 13:30 Group work presentations
13:30 – 14:30 Lunch break
14:30 – 15:00 Introductory presentation of Group work 1.2: governorate group work
- Introduction of the subject
- Description of the five planning steps for the first component
- Explanation of the procedures during group work

15:00 – 17:00 Group Work 1.2: governorate group work
17:00 – 18:30 Group work presentations

Day 2

09:00 – 09:30 Introductory presentation of Group work 2
09:30 – 13:30 Group work 2 (including coffee break)
13:30 – 14:30 Lunch break
14:30 – 15:30 Group work 2 (cont.)
15:30 – 17:30 Presentation of Group work 2

Day 3

09:00 – 10:30 Group work 2: group presentations (cont.)
10:30 – 11:00 Coffee break
11:00 – 11:15 Introduction to Group work 3
11:15 – 13:30 Group work 3
13:30 – 14:30 Lunch break
14:30 – 16:30 Group work 3: group presentations

Day 4

09:00 – 09:15 Introductory presentation of Group work 4
09:15 – 11:15 Group work 4
11:15 – 11:45 Coffee break
11:45 – 13:00 Group work 4: group presentations
13:00 – 13:30 Closing session

Annex 5. Tools and forms for group work

Tool 1. Requirements for training sites*

A. List of equipment for the classroom:

1. Large hall that can accommodate 50 people for the opening session (50 chairs, screen, overhead projector or lap top and data show.
2. Allocation of number of rooms made according to country's training policy. In each there are:
   - 8–10 comfortable chairs (according to the no. of participants, facilitators)
   - Large table 2 x 1.2 m (or smaller tables that make up the same surface area) to accommodate all participants and facilitators
   - Table for TV/video
   - Table for keeping materials
   - TV and video set
   - If possible a lap top, data show and a screen (optional: if the photos are available on CD instead of photo booklets. This depends on the training design of the country)
   - Flip chart stand
   - Source of electricity
   - Electricity connection (minimum of 2 sockets)
3. Two toilets (men and women) easily accessible by participants
4. Suitable place for coffee and lunch breaks
5. Secretariat room

B. Sites for outpatient clinical sessions:

1. High case load (not less than 40 sick under-5 children per day)
2. Two large rooms that can accommodate 14–18 persons (according to the number of participants per group) with an equal number of chairs for participants, facilitators and mothers
3. Available source of water and a basin to wash hands

C. Sites for inpatient clinical sessions:

1. Not less than 10 new sick under-5 children admitted every day
2. One ward with 7–9 beds (if the course includes only two groups of participants. Two wards might be considered if the wards are small or two sessions will be run in parallel)
3. Newborn department with good case load; minimum 8 cases per day.

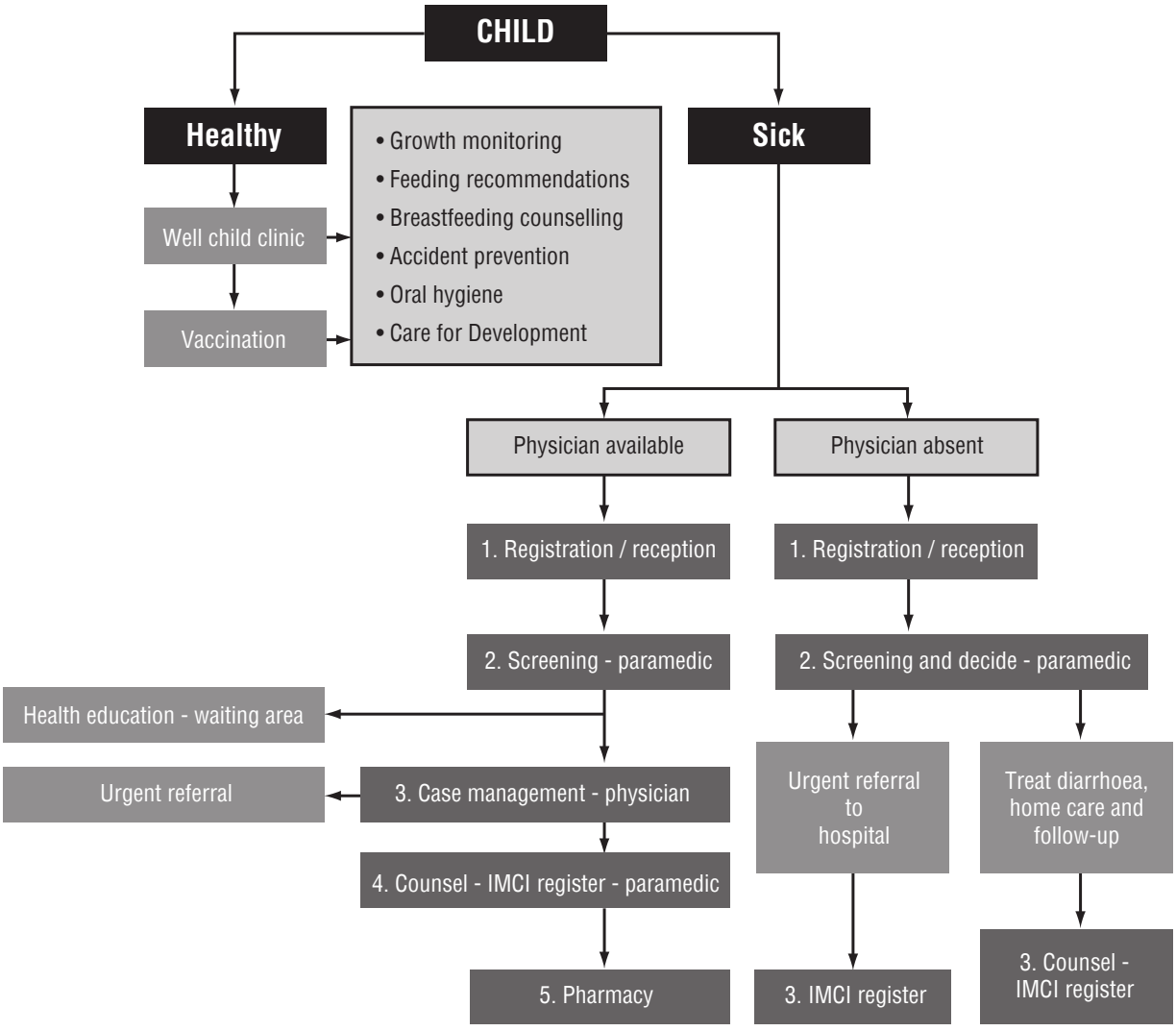
*This is subject to modification by countries according to the best available sites

Tool 2. Hints on development of district operational plan of action

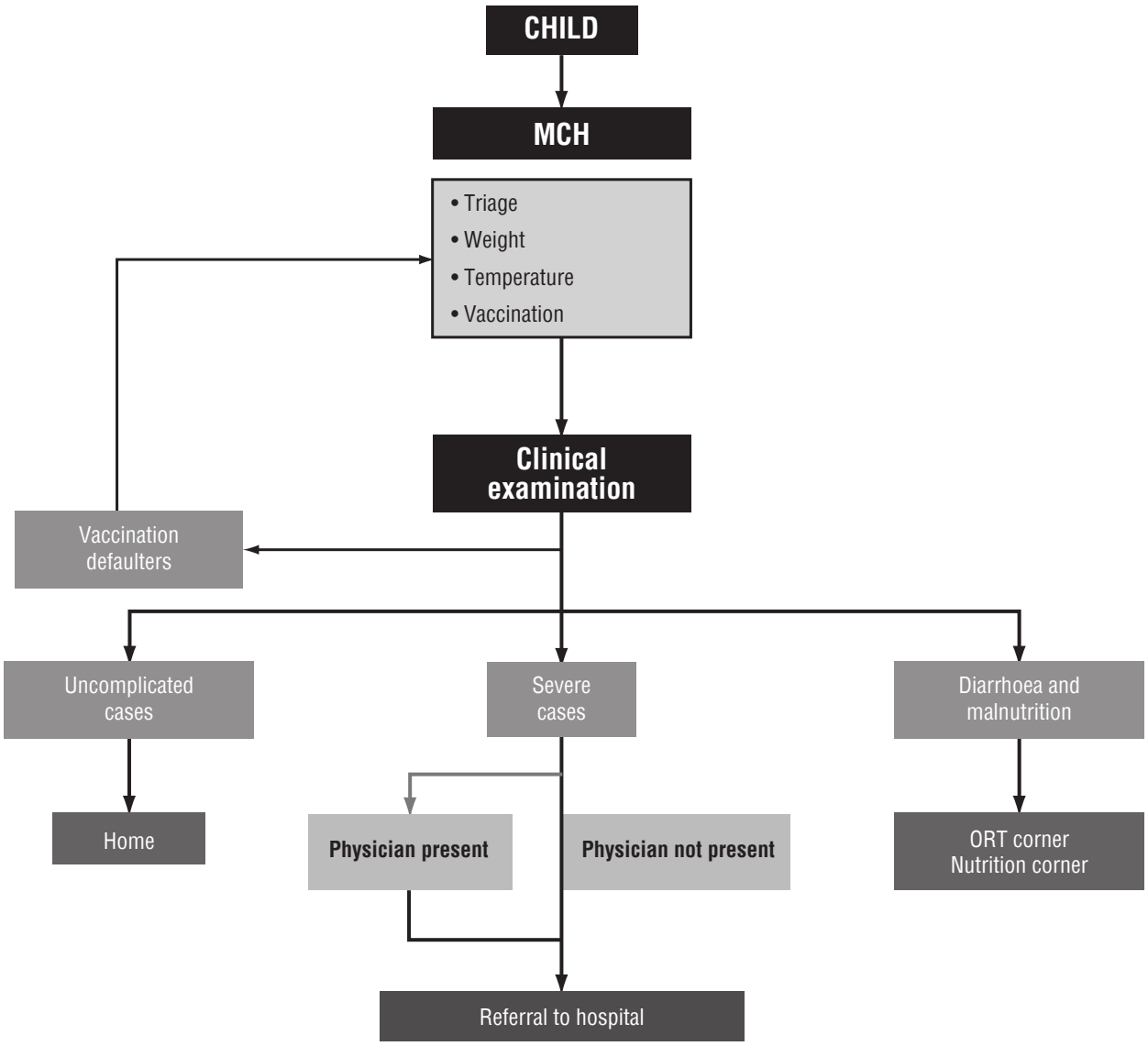
1. List all activities related to each component and divide into tasks
2. Identify responsibilities for each task and responsibility of monitoring of the implementation.
3. Set a time frame for every activity and task, avoiding over- and under-estimation of time needed based on previous experiences. Activities could be overlapping, concomitant or successive.
4. Budget activities and identify resources.
5. Things to consider:
    - The date of the first IMCI case management training course is a controlling point of time, prior to which all health facilities should be ready for IMCI implementation;
    - Long holidays or national events;
    - Identify tasks that have linkages between each other, i.e. one depends on the completion of the other, such as training providers after preparing health facilities, etc. This is called the 'critical path' as the delay of one task will lead to the delay of subsequent ones. To avoid this delay, intensive monitoring is required;
    - Avoid overcrowding tasks into a specific period of time unless it is unavoidable;
    - Avoid overburdening a limited number of staff with a lot of responsibilities at any one time. An adequate number of staff should share the responsibilities. They should be suitably qualified to undertake the responsibilities assigned to them.

Tool 3. Models of patient flow chart

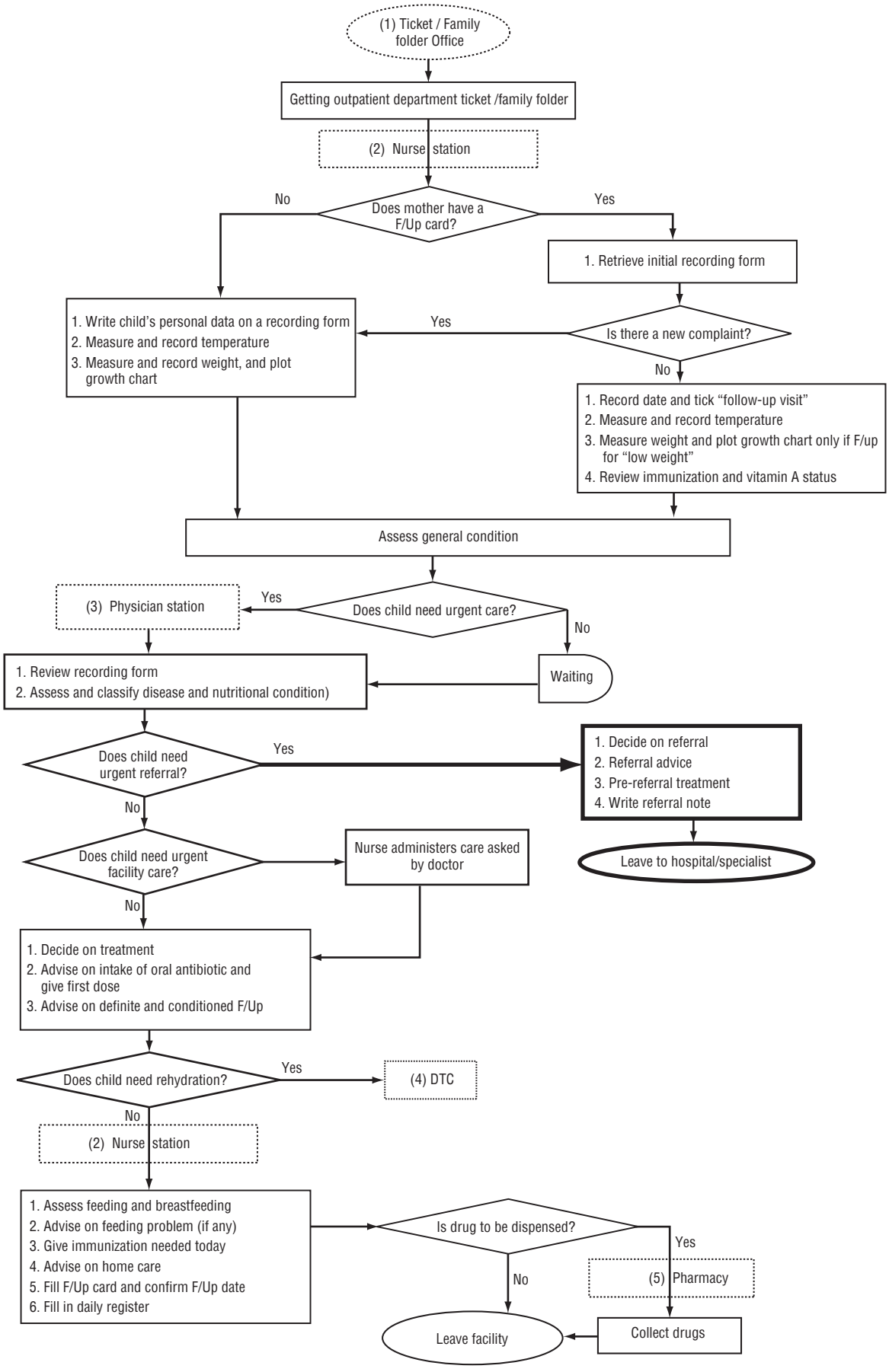
Tunisia (Model)



Djibouti (Model)



Egypt (Model)


(1) Ticket / Family folder Office
Getting outpatient department ticket /family folder
(2) Nurse station
Does mother have a F/Up card?
No
Yes
1. Retrieve initial recording form
Is there a new complaint?
Yes
No
1. Write child's personal data on a recording form
2. Measure and record temperature
3. Measure and record weight, and plot growth chart
1. Record date and tick "follow-up visit"
2. Measure and record temperature
3. Measure weight and plot growth chart only if F/up for "low weight"
4. Review immunization and vitamin A status
Assess general condition
Does child need urgent care?
Yes
No
(3) Physician station
Waiting
1. Review recording form
2. Assess and classify disease and nutritional condition)
Does child need urgent referral?
Yes
No
1. Decide on referral
2. Referral advice
3. Pre-referral treatment
4. Write referral note
Leave to hospital/specialist
Does child need urgent facility care?
Nurse administers care asked by doctor
No
1. Decide on treatment
2. Advise on intake of oral antibiotic and give first dose
3. Advise on definite and conditioned F/Up
Does child need rehydration?
Yes
(4) DTC
No
(2) Nurse station
1. Assess feeding and breastfeeding
2. Advise on feeding problem (if any)
3. Give immunization needed today
4. Advise on home care
5. Fill F/Up card and confirm F/Up date
6. Fill in daily register
Is drug to be dispensed?
Yes
No
(5) Pharmacy
Collect drugs
Leave facility

Tool 4. Note on quantification of medicines

Principles of quantification

1. Using the existing reports:

a) Obtain information on case load, i.e. total number of sick under-5 children attending the health facility during the past year and the total number of cases of ARI, diarrhoea, malaria, malnutrition, etc., if available. This depends on the available information according to the reporting policy of the country.

b) If information on the different symptoms/classification is not available, then, based on epidemiological information that provides proportion of diseases (preferably at district level, if not at national level), calculate the number of cases for each symptom using those proportions.

c) The following table shows a country example of quantification of cases for each classification based on epidemiological information available.

Classification	Proportion (example)
Total no. of diarrhoea cases	20% of total cases
Dysentery	7% of diarrhoea cases
Severe dehydration	4% of diarrhoea cases
Persistent diarrhoea	4% of diarrhoea cases
Total ARI cases	33% of total case load
Pneumonia	10% of total ARI cases
Wheeze	5% of total ARI cases
Otitis media	11% of total ARI cases
Streptococcal sore throat	25% of total ARI cases
Fever (axillary temperature ≥ 38°C)	40% of total case load
Very severe disease (for urgent referral)	0.5% of total case load
Convulsions	0.5% of fever cases
Anaemia	25% of total case load
Eye infection	10% of total case load

Example: if the total case load of sick under-5 children is 10 000 cases, using the above table,
No. of ARI cases = 10 000 x 33% = 3300 cases.
No. of pneumonia cases = total no. of ARI cases x 10%
= 3300 x 10% = 330 cases.

2. Quantification of medicines should be done for the whole district except for a few items which will be quantified at facility level basis (see item 7 below).

3. If the national IMCI guidelines identify a first and a second line antibiotic for different illnesses, quantification of the first line antibiotic should be based on the assumption that all children who need antibiotics for a specific illness will receive it. Therefore, the quantity of the first line antibiotic should be equal to the total number of respective cases. The quantity of the second line antibiotic would be calculated as 5% of the total number of respective cases.

   Example: The IMCI guidelines of a country identify amoxicillin syrup as the first line antibiotic for pneumonia and cotrimoxazole suspension as the second line antibiotic.

   Assuming the number of pneumonia cases, as calculated above, is 330 cases, then the number of amoxicillin bottles required will be 330 bottles and 17 bottles of cotrimoxazole will be needed (5% of the total amount of pneumonia cases).

4. Quantification of a medicine must take into account the dose and duration of treatment.

Example: Assuming amoxicillin syrup is the first line antibiotic for pneumonia and otitis media, the duration of pneumonia treatment will last for 5 days, while treatment of otitis media will last for 10 days. Assuming that the majority of cases will take 5 ml or less of amoxicillin three times a day (i.e. 15 ml a day for 5 days, which equals 75 ml), and knowing that an amoxicillin bottle contains 80 ml, the child will need one bottle of amoxicillin for the full duration of pneumonia treatment. The majority of otitis media cases will take 5 ml or less of amoxicillin per day, which is equal to 15 ml for 10 days, i.e 150 ml. Therefore, the child will need two bottles of amoxicillin for the full duration of otitis media treatment.

5. If the IMCI guidelines identify the same antibiotic to treat more than one illness, such as amoxicillin to treat pneumonia and otitis media cases, the calculation should take into account both conditions, and the total amount will be the sum of the two.

   Example: No. of pneumonia cases as calculated above is 330 cases, and according to the table No. of otitis media cases is equal to the following:
   = total no. of ARI cases x 11%
   = 3300 x 11%= 363 cases of otitis media
   No. of amoxicillin bottles required for pneumonia cases = 330 bottles (one bottle per case);
   No. of amoxicillin bottles required for otitis media cases = 726 bottles (two bottles per case)
   Therefore total No. of required amoxicillin bottles = 330 + 726 = 1056 bottles

6. If an antibiotic is presented in two strength forms, i.e. two different concentrations, the lowest concentration will be used for young children up to one year of age; they represent about 1/3 of the number of cases of a specific illness. Therefore, 1/3 of the quantity of the antibiotic will be in the low-strength form.

   Example: Assuming that 1056 bottles of amoxicillin are needed, 352 bottles will be provided in the low-strength form (125 mg) and the rest will be provided in the 250 mg form.

7. Some medicines are not distributed to individual patients but are used at the health facility to treat a specific group of patients, such as salbutamol solution for nebulizers and diazepam solution for the treatment of convulsions. The following should be considered:
   a) Expiry date of the open bottle
   b) Case load
   c) For those medicines, quantification should be done at facility level

   Example: No. of cases of wheeze = No. of cases of ARI x 5%
   = 3300 x 5% = 165 cases of wheeze

   Take into consideration that the expiry date of an salbutamol solution bottle is 3 months after it has been opened and contains 20 ml, which will be used for 40 children on the basis of one dose (1/2 ml) per child. If the number of cases during 3 months can be covered by less than one bottle, i.e. less than 40 children in three months, only one bottle will be provided every quarter, and the remaining solution will be discarded by the end of the 3 months. If the number of cases will need one bottle or more, the number of bottles to be provided per quarter takes into account the above calculation (one bottle for 40 cases in three months), with an extra bottle in reserve. As a principle, all opened bottles should be discarded after three months from the date of their opening.

8. An additional 10% of the estimated quantity of medicines needed from each item of medicines should be added to the total quantity to cope with the expected increase in health service utilization.

9. An increase of 10% of the estimated budget should also be considered to cope with any possible increase in medicine prices.

10. Estimation of the total budget should be done according to the latest call for bids.

Tool 5. List of basic supplies and equipment in the examination clinic at PHC and outpatient clinic of the hospitals*		
No.	**Item**	**No.**
1	Furniture	One chair for each health care provider and at least one chair for each caretaker; desk for each health provider
2	Child weighing scales	One for each health facility (preferably one per examination clinic)
3	Thermometer	Two for each clinic at any time
4	Wooden tongue depressors	One box (100 depressors) for each clinic and sufficient stock according to the caseload to ensure continuous provision for the clinics
5	Timer	One for every health care provider who will undertake child clinical management
6	Nebulizer	One for each health facility
7	Oxygen cylinder	One for each health facility and at least 15% in reserve (minimum four cylinders at the district store)
8	IMCI register	One for each clinic
9	Recording forms	Sufficient amount according to heaviest monthly case load
10	Mothers' cards	No. depends on usage: for distribution (number according to the heaviest monthly case load) or just for demonstration (15 cards)
11	Follow-up cards	Sufficient amount according to the case load

*This form is subject to adaptation by country

Tool 6. List of basic supplies and equipment for the DTC		
No.	**Item**	**No.**
1	Chairs	At least two at PHC and four at the hospital outpatient department
2	Table to keep supplies	One for each facility
3	Graduated measure	One for each health facility
4	Container to prepare ORS	One for each facility
5	Measurement vessel commonly used in the community	At least one for each facility
6	Cups and spoons	10 each
7	DTC register	One for each corner
8	Health education material	One set for each corner to be identified by each country; e.g. mothers' cards, flyers demonstrating ORS mixing and child feeding during diarrhoea, posters, etc

Tool 7. List of basic supplies and equipment for healthy child clinic*		
No.	**Item**	**No.**
1	Furniture	Chair for each health care provider One chair for each caretaker Desk for each health care provider
2	Height measure	One for each facility
3	Length measure	One for each facility
4	Strip for arm circumference	One for each facility
5	Strip for head circumference	One for each facility
6	Child files	Sufficient no. according to case load
7	Child cards	Equivalent to no. of children in catchment area
8	Growth curves	Equivalent to no. of children in catchment area
9	Clinic register	One for each health facility
10	Equipment for checking visual defects	According to country protocol, one set for each facility
11	Equipment for checking hearing defects	According to country protocol, one set for each facility
12	Health education material	No. depends on usage policy: for distribution (number according to the heaviest monthly case load) or just for demonstration (15 cards)
13	Toys	Set of various types of simple toys that suit different age groups of under-5 children, to be used for counselling mother on stimulation of child psychosocial development

* This form is subject to adaptation by country

Tool 8. List of basic supplies and equipment necessary for vaccination area*		
No.	**Item**	**No.**
1	Refrigerator with functioning thermometer	One in each health facility
2	Vaccine carrier	At least one per health facility
3	Ice bags	Six per carrier
4	Disposable syringes	Minimum amount equivalent to 1.5 times targeted population per session

*This form is subject to adaptation by country

Form 5. Human resources, case load and identification of needs per facility

Governorate: **District:**

Health facility					Human resources dealing with under-5 children								Average targeted under-5 children case load per day	Training needs
Name*	Type				No. of physicians**				No. of paramedics**					
	Hospital General/ District	Urban	Rural	Other	GP	Family doctor	Paediatrician	Other	Nurse	Medical assistant	Pharmacist	Other		
HF1														
HF2														
HF3														
HF4														
HF5														
HF6														
HF7														
HF8														
HF9														
HF10														
HF11														
HF12														
HF13														
HF14														
Total														
Maximum no. of physicians and paramedics to be enrolled in one course														
No. of IMCI facilitators existing in the district														

* Adapt the table to accommodate all health facilities targeted in the district
** Include no. of physicians and paramedics targeted for training i.e. dealing with under-5 children as defined by the country

Form 6. Situation analysis of IMCI first component (training site)

District:.....

Existing potential training site:

Yes [ ] No [ ] Location.....

Classrooms:

1. No. of available suitable classrooms.....

2. Available audiovisual aids per classroom.....

Outpatient sessions:
1. Average case load/ day.....
2. Available rooms.....
3. Available chairs.....
4. Average case load/day.....

In-patient sessions:
1. No. of new admitted under-5 children.....
2. No. of newborn cases.....
3. Available wards.....
4. No. of beds per ward.....

Existing facilitators at the governorate: (No.).....

Form 7. Identification of needs for IMCI first component in the district

Governorate: **District:**

Element	Needs/procedures	Source and responsible
Training site: Site for theoretical session Site for clinical sessions: Theoretical training aids required Furniture required		
No. of health providers to be trained: Physicians Paramedics (by category)		
Maximum no. to be enrolled in one course: Physicians Paramedics (by category)		
Facilitators required: From within the governorate, including the need to increase the pool of facilitators From outside the governorate		
Transportation means: For training For follow-up		
Accommodation possibility		

Form 8. Identification of needs for IMCI first component in the governorate		
Governorate:		
Element	**Needs/ procedures**	**Source and responsible**
Training site Site for theoretical session Site for clinical sessions Theoretical training aids required Furniture required		
No. of health providers to be trained: Physicians: Paramedics (by category):		
No. of courses		
Facilitators required: From within the governorate, including the need to increase the pool of facilitators. From outside the governorate		
Transportation means: For training For follow–up		
Accommodation possibility		

Form 9. Costing sheet

Item	Estimated cost
1. Per diem for participants (residents and non-residents)	
2. Per diem for organizing team: facilitators, clinical instructors, course director and assistants (residents and non-residents) and assistants	
3. Training materials, including medicines	
4. Stationery	
5. Logistical requirements (costing for breaks, renting a hall, etc)	
6. Transportation	
Total	

This is a guiding tool to be adapted by countries as needed

Form 10. Plan of action for IMCI first component

Form 10. Template of plan of action for any component						
Governorate: (add the name of the governorate)				**District: (add the name of the district)**		
Overall objective of the plan						
Target 1:						
Activity	**Time-frame**	**Responsibility**	**Monitoring**		**Cost estimation**	**Source of funds**
			Responsibility	**Indicator**		
1. First activity						
1.1 Activity component 1						
1.2 Activity component 2						
2. Second activity						
2.1 Activity component 1						
2.2 Activity component 2						
2.3 Activity component 3						

Form 10. Plan of action for IMCI first component

Governorate: **District:**

Overall objective of the plan: IMCI will be implemented in all health facilities of the district

Target 1: (No.) physicians will be trained to be able to cover all under-5 children attending the health facility according to IMCI guidelines and followed up.
Target 2: (No.) nurses will be trained to be able to cover all under-5 children attending the health facility according to IMCI guidelines* and followed up.

Activity	Time-frame	Responsibility	Monitoring		Cost estimation	Source of funds
			Responsibility	Indicator		
1. Preparation of the training site						
1.1 Selection of the training site						
1.2 Provision of furniture						
1.3 Provision of audiovisual aids						
2. Planning for IMCI case management training courses						
2.1 Decision on the participants for training courses						
2.1.1 Decision of the no. of training courses						
2.1.2 Decision of dates of training courses						
2.1.3 Selection of participants for each course						
2.1.4 Notification of participants for each course						
2.1.5 Organization of work at health facility during the absence of the trainees						
2.2 Decision on facilitators from within and outside the governorate for each course						
2.2.1 Determining the no. of facilitators						
2.2.2 Selection of the facilitators from within and outside the governorate for each course						
2.2.3 Notification of facilitators for each course						
2.2.4 Increase governorate pool of facilitators: include identified potential facilitators in facilitators' training course						
2.3 Logistics for facilitators and participants of the training courses						
2.3.1 Identification of the accommodation site						
2.3.2 Contact person in charge						
2.3.3 Notification of participants/facilitators on the accommodation for each course						
2.3.4 Arranging for transportation						
2.4 Conducting the training						
2.4.1 Arrangement of transportation						
2.4.2 Provision of training materials and agenda of the course						
2.4.3 Preparation of the training course						
2.4.4 Conducting the physicians courses						
2.4.5 Conducting the nurses courses						
2.4.6 Conducting courses for other categories (specify)						
3. Planning for IMCI follow-up after training						
3.1 Preparation for the follow-up visits: notification of health facilities (timing of the visit, needs for patients)						
3.2 Notification of governorate and district authorities on the district debriefing meeting (timing and venue)						
3.3 Arrangement of the transportation needed for follow-up						
3.4 Conducting the follow-up visits						

* If there are other paramedic categories targeted for IMCI training a specific target for each should be added to the plan of action

Form 11. Situation analysis of the second IMCI component

District name
Total population
Under-5 population
Under-5 mortality rate
Total no. of health facilities by type: .....Hospital .....Urban .....Rural .....Total

Item	No./tick if exists
I. Infrastructure	
1. Governmental building	
2. DTC	
2.1 Available	
2.2 Functioning	
3. Healthy child clinic	
3.1 Available	
3.2 Functioning	
4. Suitable examination area	
II. Organization of work at health facility	
1. Distribution of child care tasks among different health care provider categories	
2. Triage carried out at health facility	
3. Child case management carried out by more than two health care providers of any category	
4. Counselling caretakers carried out	
5. Duplicated child case management tasks	
6. Missing child case management tasks	
7. Smooth flow of patient	
III. Supplies and equipment*	
1. Thermometer	
2. Weighing scale	
3. Nebulizer	
4. ARI timer	
5. Wooden tongue depressors	
6. Disposable syringes	
IV. Medicines	
A. Available medicines**	
1. Existing pharmacy	
2. Amoxicillin syrup (125 mg), 80ml	
3. Amoxicillin syrup (250 mg), 80 ml	
4. Cotrimoxazole suspension	
5. Cotrimoxazole paediatric tablets	
6.	
B. Medicine storage	
Suitable medicine storage	
V. Health information	
1. Clinic registers correctly completed	
2. Regular monthly reporting	
3. Available healthy child clinic registers	
4. Available ARI register	
5. Available CDD/DTC register	
6. Child health file	
7. Child health card	
VI. Supportive supervision	
1. No. of health care programme supervisors by category	
2. Use of checklists (tick if exists)	
3. Periodicity of supervisory visits	
4. Technical supervision (tick if exists)	
5. Reports on supervisory visits	
VII. Referral system	
1. Referral system functioning	
VIII. Health service utilization	
1. No. of sick under-5 children who visited outpatient department last year	

*Supplies and equipment: write down the number of health facilities with available supplies and those with functioning equipment
**Medicines: number of health facilities where the medicine is present

Form 12. Identification of needs for IMCI second component

Element	Needs/procedures	Source and responsible
I. Infrastructure		
1. Lodging of health facilities 2. Reorganization of work space - Relocation of examination room - Provision of furniture		
II. Organization of work at health facility		
1. Organization according to set patient flow by IMCI		
III. Basic supplies and equipment		
Supplies and quantities 1. Thermometers 2. Child weighing scales 3. ARI timers 4. Wooden tongue depressors 5. Mothers' cards Equipment and quantities 1. 2. 3.	Supplies and quantities 1. 2. 3. 4. Equipment and quantities 1. 2. 3.	
IV. IMCI essential medicines		
1. Amoxicillin 2. 3. 4. 5. 6.	Medicines and quantities 1. 2. 3. 4. 5. 6.	
V. Health information		
1. IMCI recording forms 2. IMCI register 3. IMCI monthly reports 4. IMCI follow-up cards 5. DTC register 6. Healthy child clinic register 7. Child files 8. Child health cards 9. Mothers' cards 10. Growth curve		
VI. Supportive supervision		
1. No. of supervisors 2. Supervisors training needs 3. Provision of supervisory checklists 4. Provision of supervisory report template		
VII. Referral system		
1. Identification of referral site 2. Referral notes 3. Referral register 4. Orientation of referral site staff 5. Referral feedback note 6. Mechanism for handling referral feedback		
VIII. Functioning DTC		
1. Space 2. Supplies and equipment 3. Trained staff 4. Register 5. Health education material		
IX. Functioning healthy child clinic		
1. Space 2. Guidelines 3. Trained staff 4. Supplies and equipment 5. Child health file 6. Register 7. Growth curves		

(This form does not include all items necessary for child health care at primary health care facilities. Countries are urged to adapt according to the national guidelines and situation analysis)

Form 13. List of essential IMCI medicines				
Medicine according to its use*	**Quantity estimation**	**Quantity**	**Unit cost**	**Total cost**
First line antibiotic for pneumonia + acute ear infection	No. of pneumonia cases + No. of acute ear infection cases			

*The first column should be filled in from the list of IMCI medicines according to the national protocol.

Form 14. Medicine quantification and costing

Governorate:..... District:..... No. of health facilities ( )

Total under-5 children who attended health facilities:..... Average no. of ARI cases:.....

Average no. of diarrhoea cases.....

Medicine	Indication	Calculation	Quantity	Price/ unit	Estimated total cost
Amoxicillin syrup 125 mg	First line antibiotic	(1/3 cases of pneumonia x 1 + 2/3 acute ear infection x 2)			
Amoxicillin syrup 250 mg		Double the amount of 125 mg required for pneumonia			
Cotrimoxazole suspension	Second line antibiotic for pneumonia and acute ear infection	5% of the total amoxicillin needs			
Benzathine penicillin 1 200 000 IU	Streptococcal sore throat	No. of cases of streptococcal sore throat x 1			
Chloramphenicol vial 1 g	Urgent referral	No. of very severe cases x 1 x 0.6			
Crystalline penicillin 1 000 000 IU	Urgent referral for children less than two months	No. of very severe cases x 0.4 x 1			
Gentamicin ampoule 20 or 80 mg					
Erythromycin syrup					
Multi–vitamin syrup	Persistent diarrhoea	No. of diarrhoea cases x 0.02 x 1			
Paracetamol syrup	Temperature ≥ 38°C	No. of cases (total case load x 0.4) x 1			
Salbutamol syrup					
Salbutamol solution					
Tetracycline ointment for eye	Eye infections	No. of cases x 1			
ORS	All diarrhoea cases	No. of diarrhoea cases x 1 box			
Total cost					

Form 15. Plan of action for IMCI second component

Governorate: **District:**

Overall objective of the plan: IMCI will be implemented in all health facilities of the district

Target 2: (No.) health facilities will be prepared to implement IMCI by the end of ..... (month/year)

Activity	Time-frame	Responsibility	Monitoring		Cost estimation	Source of funds
			Responsibility	Indicator		
Preparation of the health facilities						
1. Infrastructure						
Lodging of health facilities						
Reorganizing the work space						
- Relocation of examination room						
- Provision of furniture						
2. Organization of work at health facilities						
3. Provision of basic supplies and equipment						
4. Provision of essential IMCI medicines						
5. Health information system						
Provision of health information system tools						
Identification of flow of IMCI information						
Identification of IMCI information processing procedures						
6. Supportive supervision						
Selection of supervisors for training						
Notification of selected supervisors for training						
Training of supervisors						
Provision of supervisory checklist and template of supervisory report						
Development of supervisory visits plan						
Arranging transportation for supervision						
Conducting supervisory visit						
7. Referral system						
Identification of referral site						
Provision of referral tools (referral note, referral feedback note…etc)						
Orientation of referral site staff						
Identification of referral feedback mechanisms						
Establishment of referral feedback mechanisms						
8. Establishment of diarrhoea treatment corner (DTC)						
Location						
Provision of supplies and equipment						
Identification of staff responsible						
Notification of staff for training						
Training of responsible staff						
Provision of health education material						
Development of health education sessions schedule						
9. Healthy child clinic						
Allocation of a space						
Provision of supplies and equipment						
Identification of a responsible staff						
Notification of staff for training						
Staff training						

Form 16. Plan of action for IMCI third component

Governorate:			District:			
Overall objective of the plan: IMCI will be implemented in all health facilities of the district						
Target 2: (No.) health facilities will be prepared to implement IMCI by the end of (month/year)						
Activity	**Time-frame**	**Responsibility**	**Monitoring**		**Cost estimation**	**Source of funds**
			Responsibility	**Indicator**		
1. Community selection						
1.1 Identification of communities for data collection						
2. Situation analysis						
2.1 Data collection						
2.2 Data analysis						
2.3 Sharing data with central team						
3. Introductory visit						
3.1 Agree on the dates of visits						
3.2 Preparation for visits						
3.3 Conducting visits						
3.4 Joint selection of communities to implement IMCI community component						
3.5 Nomination of a focal point in the selected community						
4. Orientation workshop						
4.1 Agree on dates of orientation workshops						
4.2 Identification of participants						
4.3 Preparation for workshop						
4.4 Conducting workshop						
5. Development of plan of action						

Form 17. Situation analysis of IMCI third component	
Item	**No.**
Communities that do not have access to potable water	
Communities that do not have access to sanitary human waste disposal	
Communities that have polluting factors	
Communities that have hazardous factors	
Communities that have active community structures	
Communities that have community-based interventions	

Form 18. Data collection tool for community component

Checklist of information (from the governorates)

I. Information at governorate level

1. Existing local media channels: Yes [ ] No [ ]

Cooperation with media channels: Yes [ ] No [ ]

If yes, describe:.....

2. Existing local magazine or newspapers Yes [ ] No [ ]

Which are they?.....

Existing cooperation with the Ministry of Health Yes [ ] No [ ]

If yes, describe:.....

3. Existing community/social activities and structure Yes [ ] No [ ]

If yes,

a) Describe:.....

b) Are these activities extending to the communities Yes [ ] No [ ]

If yes, list which communities and describe the activities:.....

.....

II. Information at community level

1. Functioning and successful IMCI

a) Coverage of under-5 children examined by IMCI:
No. of under-5 children examined by IMCI protocol during the last three months (from IMCI register):.....

No. of under-5 children attending health facility during last three months: (from outpatient record):.....

Calculate the coverage according to the following equation:
No. of under-5 children examined by IMCI protocol × 100
No. of under-5 children attending health facility
The number of children should be calculated for the last three months.

b) Health service utilization:
No. of under-5 children attending health facility in community during last year (from outpatient record):.....

Under-5 population in the community:.....

(Use the number of under-5 children targeted for the last polio campaign as a source for this information)

Calculate health service utilization as follows:
No. of under-5 children attending health facility during the last year × 100
Under-5 population in the community

c) Supervision
Did the health facility receive any IMCI technical supervisory visits during the last three months:
Yes [ ] No [ ]

If yes, how many:.....

By whom?.....

Is the supervisor trained in IMCI case management? Yes [ ] No [ ]

Is the supervisor trained in supervisory skills? Yes [ ] No [ ]

If no, when was the last visit:.....

By whom?.....

Is the supervisor trained in IMCI case management skills? Yes [ ] No [ ]

Is the supervisor trained in IMCI supervisory skills? Yes [ ] No [ ]

2. Potential focal point

Is there a potential focal point for the IMCI community component from the community who is: active, enthusiastic, a good communicator with good relations with the community, involved or willing to be involved, as a volunteer, in community work (from within or outside the health facility staff)? Yes [ ] No [ ]

If yes, name (him/her) and position:.....

3. Accessibility

a) Distance from the capital city of the governorate:..... km

b) Status of the road:.....

4. Community with high needs

a) Health indicators:

Infant mortality:..... per thousand live births

Under-5 mortality:..... per thousand live births

b) Existing piped potable water: Yes [ ] No [ ]
If no, what is the prevailing source of water.....

c) What is the existing sanitary disposal system?.....

d) Is there any source of environmental pollution? (for example, uncovered drainage, exposed garbage collections, industrial pollution, etc

If yes, specify.....

e) Are there hazards in the community? (e.g. unsafe water bodies, unsafe roads etc.) Yes [ ] No [ ]

f) Specific child health problems in the community:.....

5. Health education sessions at the health facility

a) Are there health education sessions conducted in the health facilities? Yes [ ] No [ ]

If yes, who is responsible?.....

How is it conducted? Seminar [ ] Video [ ] Group discussion [ ] Demonstration [ ] Other [ ]

b) Is there a schedule or programme for those sessions: Yes [ ] No [ ]

If yes, are child health issues included in this programme: Yes [ ] No [ ]

6. Community interventions

a) Are there development projects within the community?

If yes, what are they?.....

Who is the responsible body?.....

b) Are there NGOs working in the community? Yes [ ] No [ ]

If yes, What are they?.....

Are they involved in community-based health activities? Yes [ ] No [ ]

If yes, in which health area?.....

If no, what are their community based activities?.....

7. Community structure

a) What are the existing structures involved in the community work?

Raedat rifiyat [ ] Women's club [ ] Literacy classes [ ]

Youth club [ ] Community volunteers [ ] Other [ ] Specify.....

b) Who are the community leaders who might be potential structures for community work?

Omda [ ] Influential woman [ ] Village council [ ] Physician [ ]

Imam [ ] Teacher [ ] Other [ ]

Form 19. Plan of action for monitoring and documentation (example)

Governorate: (add the name of the governorate) **District: (add the name of the district)**

Overall objective of the plan: IMCI will be implemented in all health facilities of the district

Target 4: a) All elements of IMCI plan of action monitored
b) All IMCI implementing health facilities monitored
c) All events and activities of IMCI implementation documented

Activity	Responsibility	Time-frame	Monitoring	
1. Monitoring			Indicator	Responsibility
1.1 Activities of first component				
1.1.1 Preparation of training site				
1.1.2 ------				
1.1.3 ------				

1.2 Activities of second component				
1.2.1 Provision of medicines to health facility				
1.2.2 -----				
1.2.3 -----				

1.3 Activities of third component				
1.3.1 Community situation analysis conducted				
1.3.2 --------				
1.3.3 ------				
------				
2. Documentation				
2.1 Tools adapted/developed				
2.2 Sharing of reports				

Form 20. Checklist for preparatory arrangements

Tasks		Date initiated	Date completed	Notes
Administrative tasks				
1	Determining dates and venue			
2	Determining numbers and titles of participants			
3	Reserving workshop location			
4	Sending formal letter to concerned governorates			
5	Starting formalities to release allocated funds			
6	Arranging travel and lodging			
7	Production of adapted materials			
8	Checking and preparing needed equipment and supplies			
9	Arranging catering			
10	Preparing workshop site			
Technical tasks				
1	Preparing workshop schedule			
2	Adapting of forms and presentations			
3	Designating facilitators and their tasks			
4	Facilitators meeting			
5	Assigning rapporteur			

Form 21. Checklist of materials and supplies for the district planning workshop

Checklist of materials

1. Agenda [ ]
2. Template [ ]

Checklist of stationery

1. Pens [ ]
2. Pencils [ ]
3. Transparencies for writing [ ]
4. Notebooks [ ]
5. Markers for writing on transparencies [ ]
6. Flip chart stands and papers [ ]
7. Markers for writing on the flip charts [ ]

Supplies

1. Electrical connections [ ]
2. Audiovisual aids: laptop computers, datashow projector, or overhead projector(s) and screen(s). These aids should be checked prior to the start of the workshop [ ]

Form 22. Gantt chart

Governorate:			District:														
Overall objective of the plan:																	
Target 1:																	
Activity	**Responsibility**		**No. and date of the beginning of the week**														
Week no.	**Implementation**	**Follow-up implementation**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
I. First activity																	
Activity component 1																	
Activity component 2																	
2. Second activity																	
Activity component 1																	
Activity component 2																	
Activity component 3																	

Form 23. An example of an events record

Date	Event	Description	Notes
2/10/2007	*Training of situation data collectors*	*(Mr X, Ms Y and Mr Z) were provided with the tools and trained at (specify venue)*	*Carried out by an IMCI central team member*
9–22/10/2007	*Situation data collection*	*The team collected data from the district office, hospital and the 24 health facilities*	
17–25/11/2007	*Case management training*	*24 doctors from 20 facilities were trained*	*Providers in four facilities had not been trained yet*

Form 24. An example of a training record

District name ..... **Name of health facility .....**

Name	Title	Date joined the facility	Training subject	Dates	Situation change
Dr	*Doctor*	*18/3/2005*	*IMCI CM*	*2-8/5/2006*	*Transferred to Sharq health centre on 9/7/2007*
Mrs	*MCH nurse*	*27/5/2004*	*IMCI CM*	*9-12/5/2006*	*Maternity leave from 10/9/2007*
Ms	*OPD nurse*	*2/9/2005*	*IMCI CM*	*9-12/5/2006*	
Dr	*Doctor*	*12/7/2007*	*IMCI CM*	*9-15/11/2007*	