"IMCI implementation was associated with a doubling in annual rate of under-5 mortality reduction". This is how the article published in "BMJ Open", 2012 concluded a retrospective study on the impact of IMCI implementation in Egypt.

Since its introduction in 1996, IMCI was adopted as a primary child health care programme and not as a training programme; a national IMCI programme at the Ministry of Health was established with a strong political and partner support.

Egypt went through the following main steps:

First, advocacy, through workshops for high-level decision-makers, involvement of all concerned partners and early involvement of academe and professional medical associations. As a result, IMCI was included into existing strategic national initiatives such as Basic Benefit package of the health sector reform in 1999, national strategic health plan, etc.

Second, establishment of IMCI structure, a national programme, composed of a central IMCI unit and governorate and district coordinators led the implementation with government budget line allocation.

Third, planning for IMCI implementation.

Equity, quality, accountability, sustainability, partnerships are the 5 main planning principles of national plan adopted in 1999, with the target of providing quality care by all primary health care units in the country in accordance with IMCI guidelines by 2010. Well-defined IMCI indicators were developed and monitored. A parallel replacement plan adopted to overcome the high turnover of trained physicians.

Fourth, IMCI implementation: systematic approach.

The regional systematic approach for scaling up with well-defined sequential steps and quality criteria for each step was adopted. Timely documentation and advocacy throughout the process are systematic.

The key steps are:

- selection of governorates based on criteria: population, mortality, geographic location;
- orientation of governorate officials;
- situation assessment of managerial capacity in districts and health facility readiness;
- district planning workshops to develop comprehensive plans on IMCI 3 components (training, health system elements and community-based activities), to create ownership of governorate and district staff;
- capacity-building through decentralized quality training of adequate number of staff enough to manage all sick children according to IMCI guidelines, tailored to job description of care providers;
- timely documentation, monitoring and evaluation through monthly reports from health facilities, quarterly reports from governorates, national database on IMCI programme implementation and service delivery, annual reports, quarterly feedback from the central unit and problem solving.

In addition, the programme worked intensively on sustainability measures incl. pre-service education, which represents a real success story in the Region.

As a result, IMCI coverage rose from 3% of primary health care facilities in 2000 to 98% in 2012; 95% of trained staff received a follow-up after training visit.

Evaluation (incl. visits, reports, reviews and survey) showed dramatic improvement of quality of children care by health providers trained in IMCI and substantive improvement in related health system elements (medicines, supervision)

In conclusion, key factors of success include: strong programme structure with staff specifically dedicated to IMCI implementation at national, governorate and district levels enabled implementation of activities according to plans; stepwise introduction of IMCI strategy at governorate and district levels; involvement of concerned partners throughout the process led to sustaining a high level support; implementation of IMCI as a primary child health care

programme within which training was only one of the components to be scheduled once there was readiness in health facilities; high percentage of trained staff followed up after training helped solving problems and taking timely corrective measures; using indicators and quality criteria for each step provided IMCI coordinators and district health managers with clear guidance on what and how to implement and how to assess quality.

Finally, Egypt experience offers a successful example in implementing IMCI at national scale in a country with large population that is relevant to other settings and be replicated to reduce child mortality.

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