Provinces which have started implementing IMCI
Districts which have started implementing IMCI
Health facilities implementing IMCI Graphs
Health providers trained in IMCI
IMCI case management training courses conducted
INTRODUCTION PHA\$E
IMCI strategy formally endorsed by the Minister of Health (ministerial decree); IMCI Working Group and
April 2003
EARLY IMPLEMENTATION PHASE
Adaptation of IMCI clinical guidelines completed (training materials then adapted and translated into D
August 2003

National IMCI Planning Workshop
August 2003
First 11-day IMCI case management course at central level for doctors conducted
October 2003
IMCI early implementation phase started at district level
February 2004
IMCI considered for inclusion in the paediatric curriculum of medical schools (during review of medical s
April 2004
First IMCI follow-up visits after training conducted
May 2004

Early implementation phase in 7 clusters/districts in 3 provinces completed
October 2004
Review of Early Implementation Phase and planning for the Expansion Phase conducted
December 2004
EXPANSION PHASE
Beginning of expansion to new clusters/districts and provinces
2005
IMCI clinical training
Targeted coverage of providers at health facility
Course duration
Materials Targeted coverage of providers at health facility
rangotou coverage or providers at nearth facility

Health providers managing children under-5 at Basic Health Centres (BHC),	Comprehensive
Health Centres (CHC), and outpatient departments of selected hospitals.	

Course duration

Eleven-day case management courses.

Materials

Training materials adapted, based on the Afghanistan adapted IMCI clinical guidelines, and translated in Dari and Pashto.

Systematic approach to IMCI implementation at district level: key steps and tools

1.

Selection of districts for IMCI implementation

2.

Ensuring drug availability

3.

Setting up IMCI coordination mechanisms

4.

Orientation meeting

5.

Selection of training sites and trainees

6.

Training in case management (skill acquisition)
7.
Training in facilitation and follow up skills
8.
Follow up after training (skill reinforcement)
9.
<u>Documentation</u>
1. Selection of districts for IMCI implementation
Criteria used to select the districts for the Early Implementation Phase included the following:
1.
Commitment of district staff
2.
Presence of accessible referral facilities
3.
Drugs required for IMCI implementation available at health facilities
4.
Good access to central staff, to facilitate monitoring. Top

2. Ensuring drug availability

Drugs recommended by the IMCI protocols, already listed in the national essential drug list, were included in the Basic Package for Health Services (BPHS). These drugs were made available to sick children free of charge in most health facilities. Top

3. Setting up IMCI coordination mechanisms

A management and coordinating structure was established in Nangarhar, where a task force was set up, including staff from the ministry of health, medical school and NGOs (non-governmental organizations). In Nangarhar, three coordinators were selected for the following areas: health provider skill development (in-service training) and community, health system support, and pre-service education, respectively. In Wardak, a medical officer from an NGO which provided health care services in the province was appointed as the coordinator for IMCI. The IMCI central unit closely coordinated IMCI activities in Kabul with the provincial health director. Top

4. Orientation meeting

IMCI orientation meetings were organized for members of the provincial task force with support from the central level. Top

5. Selection of training sites and trainees

Training sites were selected to provide sufficient caseload and variety of conditions for demonstration and practice during clinical training in the provinces. Most of the participants selected for training courses were responsible for managing children at first-level health facilities and had good reading skills. Top

6 Training in case management (skill acquisition)

Eleven-day training courses were conducted, following the WHO IMCI training quality criteria. Top

7. Training in facilitation and follow up skills

An initial pool of facilitators, clinical instructors and supervisors was created both at national and provincial level to build capacity for training and follow-up visits. Top

8. Follow up after training (skill reinforcement)

Three rounds of follow-up visits were conducted to almost all health facilities in which staff had been trained in IMCI. Top

9. Documentation

IMCI documentation has been based on: information on performance of health providers, and caretaker knowledge about home care and satisfaction with health services collected during follow-up visits; and reports on clinical courses and IMCI activities. During planning, consideration was given to incorporating IMCI classifications in the Health Management Information System (HMIS) for reporting purposes. Top

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