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INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI)

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1. Introduction

The Integrated Management of Childhood Illness (IMCI) strategy was developed by the Pan American Health Organization/World Health Organization (PAHO/WHO) and the United Nations Children's Fund (UNICEF) to reduce mortality and morbidity in children under 5 and improve the quality of care in the health services and the home. During its preparation individual strategies already available for controlling illnesses and specific health problems were incorporated to permit the integrated evaluation of a child's health when it comes into contact with any health care provider, whether institutional or community-based. The IMCI strategy, moreover, includes disease prevention and health promotion activities, turning the consultation into an opportunity to improve knowledge, attitudes, and the practices employed in caring for the child in the home. By integrating diagnosis and treatment of the most frequent illnesses, prevention measures, and health promotion into a single evaluation sequence, IMCI reduces missed opportunities for early detection and treatment of problems, for vaccination, for the detection of nutritional disorders, and for educating parents in the proper care of the child in the home and the early detection of warning signs to encourage them to seek help in a timely fashion.

2. Child Health in the Region of the Americas

Although the infant mortality rate (IMR) in the Region of the Americas has declined steadily, especially in the past decade, profound differences can still be seen among the countries. The IMR in some countries of the Region is still 10 times higher than that of the most developed countries in the Hemisphere (Table 1, Figure 1), and in many countries, at the twilight of the 20th century, the IMR is similar to what it was in the first half of this century. Differences in the IMR cannot only be observed between the developed countries and the developing countries; among these latter, the differences are very marked as well. In all the countries the IMR reflects only the national average, concealing the marked differences between populations, whether grouped by geographical location, race, or income level.

The difference in the magnitude of the IMR is largely associated with the persistence of high mortality from infectious and parasitic diseases in the developing countries, especially those with lower incomes; here, mortality rates are more than 200 times higher than those found in the developed countries of the Hemisphere. In the developing countries, acute respiratory infections (ARI), diarrhea, and malnutrition are the cause of most infant mortality, and together account for 40% to 60% of all deaths in children under 5; in the developed countries they are the cause of less than 6% of the deaths in this age group.

Table 1: Infant Mortality in the Region of the Americas
Estimated Figures and Information for 1986, 1991, and the Last Available Year

COUNTRY	Estimated Figures (1) 1995–2000		Official information						
			1986		1991		Last available year		
	No.	RATE *	No.	RATE*	No.	RATE*	YEAR	No.	RATE*
TOTAL	**424275**	**28**	**349991**	**21.39**	**273177**	**17.59**	------		
NORTH AMERICA	**28427**	**7**	**41829**	**10.13**	**39337**	**8.72**	------		
CANADA	2142	6	2938	7.89	2571	6.39	1994	2418	6.28
UNITED STATES	26285	7	38891	10.35	36766	8.94	1995	29538	7.47
SOUTH AMERICA	**252377**	**36**	**218507**	**25.90**	**151706**	**21.29**	------		
BRAZIL	134820	42	132211	24.79	86319	23.90	1995	81576	24.09
SOUTHERN CONE	**26686**	**22**	**27035**	**25.61**	**24389**	**21.78**	------		
ARGENTINA	15708	22	18163	26.89	17152	24.69	1995	14606	22.17
CHILE	3796	13	5220	19.12	4385	14.89	1994	3438	11.93
PARAGUAY	6318	39	2150	40.10	1695	24.02	1993	1910	24.77
URUGUAY	864	16	1502	27.90	1157	19.28	1994	1056	16.97
ANDEAN AREA	**90871**	**35**	**59261**	**28.95**	**40998**	**17.13**	------		
BOLIVIA	17030	65	****		****			****	
COLOMBIA	20952	24	16193	19.09	12849	14.35	1994	11302	12.99
ECUADOR	13905	45	10372	50.40	4244	15.64	1995	5533	18.57
PERU	26972	44	19668	40.28	11511	18.44	1995	13377	21.82
VENEZUELA	12012	21	13028	25.83	12394	20.59	1994	13576	24.78
CENTRAL AMERICA	**38558**	**36**	**20782**	**32.77**	**17404**	**32.80**	------		
COSTA RICA	1044	12	1480	17.79	1124	13.86	1994	1045	13.00
EL SALVADOR	6346	38	4156	29.52	****		1996	2358	14.43
GUATEMALA	16600	40	10004	41.82	12139	43.73	1993	12586	43.06
HONDURAS	6902	34	****		****		1983	2758	17.41
NICARAGUA	6364	43	4025	35.52	3062	27.38	1996	2358	20.09
PANAMA	1302	21	1117	19.37	1079	17.96	1993	1104	18.65
LATIN CARIBBEAN	**29301**	**44**	**7028**	**16.24**	**6107**	**13.06**	------		
CUBA	1305	9	2262	13.62	1853	10.66	1996	1109	7.92
HAITI	20910	82	****		****			****	
PUERTO RICO	585	9	871	13.78	841	12.52	1992	821	12.09
DOMINICAN REPUBLIC	6501	33	3895	19.14	3413	15.05	1995	1913	20.59
MEXICO	**72478**	**31**	**60516**	**23.60**	**57051**	**20.70**	**1994**	**49845**	**17.16**
CARIBBEAN	**3121**	**19**	**1329**	**7.92**	**1572**	**11.68**	------		
ANGUILLA	5	26	3	15.00	2	10.00	1995	5	25.00
ANTIGUA AND BARBUDA	19	19	3	2.65	4	4.00	1992	4	4.00
NETHERLANDS ANTILLES	60	15	****		****		1981	95	23.75
ARUBA	8	8	****		****		****		
BAHAMAS	70	14	175	30.22	122	23.81	1995	99	15.83
BARBADOS	36	9	77	18.92	65	15.35	1995	55	15.41
BELIZE	203	29	152	24.60	83	12.36	1995	95	17.42
DOMINICA	14	14	26	15.11	28	16.37	1995	24	15.99
GRENADA	60	20	****		****		1988	59	22.38
GUADELOUPE	64	8	****		****		1985	103	15.30
FRENCH GUIANA	80	20	105	43.90	****		1986	105	43.90
GUYANA	1083	57	****		****		1994	554	38.10
CAYMAN ISLANDS	4	8	5	13.89	7	14.00	1994	2	4.00
TURKS AND CAICOS ISLANDS	4	19	4	7.68	1	5.00	1995	10	38.02
VIRGIN ISLANDS (U.K.)	8	20	5	7.68	5	12.50	1995	8	27.30
VIRGIN ISLANDS (USA)	33	13	****		****		1980	63	24.70
JAMAICA	660	12	****		672	11.22	1991	672	11.22
MARTINIQUE	49	7	****		****		1985	54	9.40
MONSERRAT	2	12	****		3	17.14	1994	1	5.00
SAINT KITTSAND NEVIS	27	27	39	38.73	15	16.39	1995	18	18.83
SAINT VINCENT AND THE GRENADINES	36	18	67	24.74	57	22.00	1991	57	22.00
SAINT LUCIA	57	19	79	19.70	67	17.93	1995	59	17.25
SURINAME	230	23	237	23.29	196	21.53	1992	113	12.02
TRINIDAD AND TOBAGO	308	14	355	11.13	247	8.23	1994	272	13.82
OTHERS	***13***	***13***	***13***	***14.62***	***7***	***7.77***	------		
BERMUDA	13	13	13	14.62	7	7.77	1994	16	17.76
FALKLAND ISLANDS	****		****		****		1983	0	0.00
SAINT PIERRE AND MIQUELON	****		****		****		1981	1	9.20

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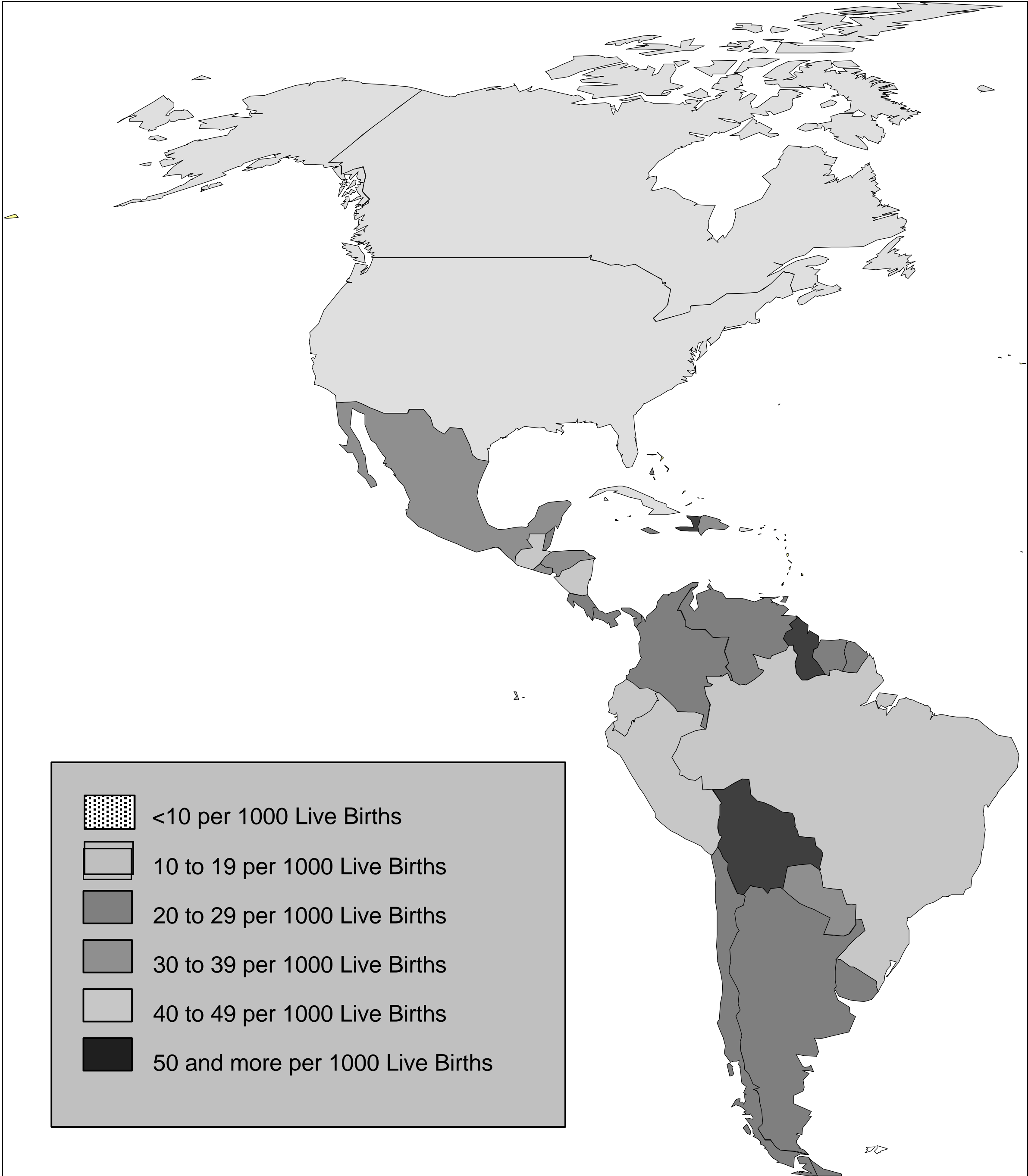
* Rates per 1000 live births **** No data

**Figure 1: Infant Mortality in the Countries of the Americas
Estimates 1995-2000**



Associated with infectious diseases, such as malaria, tuberculosis, dengue, Chagas' disease, vaccine-preventable diseases, and meningitis, these three conditions also constitute the highest burden of disease in the child population, responsible for more than 60% of the visits to the health services and more than 40% of the hospitalizations of children under 5. Every day considerable resources are invested in their diagnosis and treatment--many of them unnecessarily, as in the case of antibiotics, since more than 50% of the children who are given these drugs do not need them to be cured. This practice leads to antimicrobial resistance, higher treatment costs, and frequent drug shortages in the health services, keeping many children who do need the drugs from receiving them.

Controlling these problems in children poses the challenge today of achieving a health situation that is more equitable and compatible with the knowledge and technology available and can be put within reach of the population through health services and health workers at the first level of care. The IMCI strategy is offered as the best alternative for achieving this end, for it not only focuses on controlling the leading causes of mortality and morbidity in children but is an adequate vehicle for improving the quality of care in the health services and the home.

3. The IMCI Strategy and Child Health

3.1 *Response to the Demands of the Population*

Focusing on the rapid detection and treatment of the illnesses that affect children and put them at risk of death, the IMCI strategy permits an immediate response to the main problem that brings the child to the health service. Thus, implementation of the IMCI strategy responds to the principal concerns of the population regarding the health status of children.

3.2 *Strengthening the Integrated Approach to Care of the Child*

Application of the IMCI strategy permits a thorough assessment of a child's health status, leading to the detection of other problems and illnesses, even when they are not the main reason for the consultation. In this way, the IMCI strategy reduces missed opportunities for the early detection and proper management of childhood illnesses, which often go untreated because they are not detected by health workers.

3.3 *Strengthening the Application of Prevention Measures*

The IMCI strategy also includes the systematic assessment of the vaccination and nutritional status of the child, as well as activities to guarantee disease prevention and reduce the prevalence of malnutrition, a highly important risk factor that aggravates illness and increases infant mortality. For this reason, application of the IMCI strategy

reduces missed opportunities for vaccination and for the detection and treatment of nutritional problems in the child.

3.4 *Encouraging Health Promotion Activities*

By including specific educational components on caring for the child in the home, as well as disease prevention and the early detection of warning signs, the IMCI strategy helps to improve the knowledge, attitudes, and practices of the population with respect to child health. It thus becomes a vehicle for improving the family's ability to care for the child at home, thereby contributing to disease prevention and health promotion.

3.5 *Improving the Efficiency and Quality of Care*

The IMCI strategy guarantees detection of the main causes of illness in children through the application of a basic set of assessment, classification, and treatment activities, selected for their high predictive value for early detection and successful treatment. Thus, the IMCI strategy is an adequate tool for providing the highest possible quality of care during a routine visit to the health services. By establishing a systematic sequence for assessment, classification, and treatment that includes the components of disease prevention and health promotion, application of the IMCI strategy guarantees proper care for all children, thus improving equity in the access to the available knowledge and technologies for the prevention and treatment of illness.

4. Implementing the IMCI Strategy

4.1 *Adaptation to the Needs of Each Country*

Taking the different health situation of the countries into account, implementation of IMCI involves the adaptation of the content and methodologies of the strategy to bring it into line with the epidemiological and operational situation in each country and in the different areas within the countries. Thus, the IMCI strategy can be targeted toward the leading causes of illness in each location, guaranteeing the speedy detection of serious problems, the corresponding outpatient treatment, and the application of disease prevention and health promotion measures for the child that are suited to the particular context of each place.

4.2 *Implementation Geared toward Improving Equity*

Application of the IMCI strategy in the health services improves equity in health care, since it guarantees access to a basic series of measures for the early detection and treatment of illness, disease prevention, and health promotion to all children. Gearing its implementation first toward the countries and areas with the highest IMR, PAHO/WHO

is helping to reduce the existing gaps in the health situation of children, thereby reducing the inequities between countries and between areas of the same country in terms of child mortality and morbidity, as well as access to adequate quality care.

4.3 *Strengthening the Decentralization Processes*

Implementation of the IMCI strategy also strengthens the decentralization processes, extends the coverage of measures to control childhood illness, and improves intersectoral coordination and the quality of referral and back-referral between the community, the first level of care, and the hospitals. By improving the problem-solving capability of the basic levels of care, including the family and the community, the strategy bolsters the decentralization process, which includes strengthening the decision-making capability of the peripheral levels to give them greater autonomy in organizing activities. The community component of IMCI is an adequate tool for extending the coverage of care for the principal child health problems, involving auxiliary personnel, community health workers, other volunteers, and the family itself in disease prevention and health promotion activities on behalf of children. Finally, implementation of the IMCI strategy strengthens the links between the different levels and sectors of care, establishing uniform criteria for assessment, classification, treatment, and monitoring of the progress of the illness, optimizing the use of all available resources, both public and private.

4.4 *Strengthening Interaction and Links between Countries*

The implementation process is moving forward in the Region, generating significant mobilization in the countries and promoting the sharing of experiences and activities among them. The formation of a critical mass of trained health workers for monitoring and evaluating activities and for conducting multicenter studies aimed at generating more in-depth knowledge about the problem is making it possible to develop intercountry plans, share and complement experiences, and support the national and local levels in the strategy's implementation. This process extends not only to the ministries of health but to scientific societies, the universities, and medical and nursing schools, thus contributing to the dissemination of the IMCI strategy and its discussion in academic and scientific forums at the national and international level.

5. The International Context

Child health has been the deserving object of profound and continuing interest in recent years, given the unacceptable disparities in the situation of children in the different countries of the world. The goals issued by the World Summit for Children constitute one of the more important advances in this regard and are among the factors that moved PAHO/WHO and UNICEF to search for an integrated tool that would enable children to

receive adequate care--care that would guarantee the early detection and proper management of all their health problems, not just those that precipitated the consultation, while incorporating disease prevention and health promotion activities. The IMCI strategy, the fruit of a joint effort by PAHO/WHO and UNICEF, is currently presented as a suitable alternative for improving the care of children under 5 in both the health services and the home.

The suitability of the IMCI strategy for achieving a significant reduction in child mortality and morbidity and for guaranteeing adequate quality health care for children was noted by the World Bank in its 1993 Report, which called it the most cost-effective intervention for reducing the burden of disease in the population. Within this context, implementing the strategy in the health services is very important for improving the health conditions of the population. It is an integral part of health sector reform--a tool for decentralization, for improving the efficiency and quality of care in the health services, and for strengthening the State's role in developing health policies for intersectoral application.

In order to implement the strategy, PAHO/WHO and UNICEF–TACRO joined forces, as provided in the interagency agreement signed in 1996, which paved the way for ongoing regional and country coordination to assist national authorities in incorporating the IMCI strategy in the health services and the community. The agreement between PAHO/WHO and USAID to assist the countries in achieving universal access to the IMCI strategy by children under 5 constitutes a framework for additional support, strengthening implementation of the IMCI strategy in the countries and pooling the efforts of the various agencies working to improve the health conditions of children. Commitment at the national level has been essential for implementing the IMCI strategy. It began with the Declaration of Santa Cruz de la Sierra, drafted by the national authorities in charge of ARI and diarrheal disease control in the developing countries. In this Declaration they expressed their commitment to the activities and to the efforts required to ensure that all children under the age of 5 in the Hemisphere have access to the IMCI strategy through the health services and health workers, as well as the community structures in each country, which include various types of volunteer and community-based personnel. The commitment of technical personnel has been accompanied in some countries of the Region of the Americas (Bolivia, Ecuador, Peru, and Dominican Republic) by official adoption of the IMCI strategy as the basic health policy for securing a reduction in infant mortality.

Broad support for the IMCI strategy has helped to mobilize numerous governmental and nongovernmental resources, achieving a different degree of commitment in each country. The introduction of the IMCI strategy as the principal health care instrument for children is under way among some private health facilities in Colombia and in numerous institutions supported by nongovernmental organizations

(NGOs) in Bolivia, Ecuador, El Salvador, Peru, and the Dominican Republic. In some countries implementation of the IMCI strategy is being fully coordinated with the health sector reform process, with the strategy constituting one of the essential elements in the basic package of services to be offered by the health system and a tool for improving the problem-solving capability of the system.

Cooperation among countries in the implementation process was strengthened from the regional level, permitting the sharing of experiences and support from countries in the areas in which they showed the greatest strength. There was also cooperation with the institutions responsible for educating health workers, the purpose of which was to incorporate teaching of the IMCI strategy into the training process to strengthen implementation in one of the most important components: training the staff that care for the child in the application of the IMCI strategy.

6. Progress in Implementing the IMCI Strategy in the Region

6.1 *Implementation Priorities at the Regional Level*

Since its unveiling in 1996, 14 countries of the Region have begun implementation of IMCI, giving priority to the areas with the highest IMR, where the strategy can have the greatest impact in terms of reducing child mortality and morbidity. Actions were targeted from the regional level to support the countries with the highest IMR, thus ensuring the adoption of the IMCI strategy in Bolivia, Brazil, Ecuador, Peru, and the Dominican Republic in 1996, and El Salvador, Haiti, Honduras, and Nicaragua 1997. In 1998 progress was made in presenting the IMCI strategy to other countries in the Region where activities for its application were already under way, namely Argentina, Colombia, Guatemala, Paraguay, and Venezuela, and activities are programmed for adapting the IMCI strategy to the national policies of other countries, particularly Guyana and Mexico.

6.2 *Adapting the IMCI Strategy to the Situation in Each Country*

All the countries that began implementation of the IMCI strategy adapted its contents to the local epidemiological and operational situation. This made it more relevant while promoting the commitment of academic and scientific institutions in the countries that actively participated in the adaptation process.

6.3 *Training Health Workers*

All the countries that have already initiated the implementation process have held training courses for train health workers. This activity began with the training of a critical mass to support the national effort, currently reaching the first level health services,

which are gradually incorporating use of the IMCI strategy in health care for children under 5. Over 5,000 people have been trained in these countries to date, and their numbers are constantly increasing.

6.4 *Support and Follow-up for Effective Implementation*

Follow-up after training has demonstrated the feasibility and benefits of the IMCI strategy for improving the quality of health care for children, although it has not achieved the coverage necessary to guarantee that all trained staff will receive assistance in introducing the IMCI strategy in the routine care provided by the health services. The implementation of this follow-up has revealed a significant sharing of experiences among the countries, which are providing mutual support to guarantee the effective application of the strategy in the health services.

6.5 *Increased Access through Intersectoral Coordination and Participation*

The implementation process has led to closer ties with the academic and scientific institutions of the countries, with NGOs working locally, and with the social security institutions, helping to incorporate the IMCI strategy in the different sectors of care and in the education of health workers. Through the development and testing of materials and tools designed to strengthen the community component of the IMCI strategy, progress has been made in integrating community health workers (CHW) to increase access by population who cannot obtain timely care through the institutional health services and health workers. Training courses for auxiliary and support have also been designed to guarantee the early detection of critically ill children and improve interpersonal communication with mothers in order to instill the knowledge, attitudes, and practices necessary for improving care for the child in the home.

6.6 *Epidemiological and Operations Research for Surveillance*

Finally, the implementation of simple protocols for the surveillance of childhood illness began for the purpose of conducting epidemiological and operations research to increase local knowledge about the health problems of children and to assess the impact of the IMCI strategy on these illnesses. Some of these studies, either completed or in progress in some countries, have already revealed the benefits of the IMCI strategy, i.e., a reduction in the unnecessary use of antibiotics and in the prescription of unsuitable drugs for case management, such as antidiarrheals and cough syrups.

6.7 *Adapting the Strategy to Countries with Lower IMR*

To achieve a real impact in terms of improving the quality of care, the IMCI strategy was adapted to the epidemiological situation of countries with lower IMR, such

as Argentina, Brazil, and Colombia. This action will help to improve the quality of health care for children, increase the coverage of measures for disease prevention and health promotion, and enhance the ability of families to provide adequate care for children in the home.

7. Challenges for Implementation

PAHO has played a key role in regional and national efforts to improve the health conditions of the population in general and children in particular. Supporting and guiding activities in disease prevention and control, PAHO has contributed to the progress made by the countries in strengthening primary health care and achieving the goals of health for all by the year 2000. It has also helped to achieve the goals of the World Summit for Children to reduce mortality in children under 5 by one third and decrease the incidence of health problems.

The regional initiatives for polio and measles eradication, currently under way, have demonstrated the capacity of the Region of the Americas to confront challenges and have served as a guide for other regions along the steady path toward better health and living conditions for the population.

The possibility of continuing to contribute to a sustained reduction in mortality in children under 5 by reducing mortality from infectious diseases implies a responsibility to guide regional and national efforts toward better health conditions for the population.

Implementation of the IMCI strategy to permit universal access by children under 5 to health services and health workers and to ensure that the population follows the recommendations on disease prevention and health promotion for children will make it possible to move toward the goal of reducing mortality. Thus, it will help to prevent more than 100,000 deaths in children under 5 in the year 2002, based on the annual figures for 1995–2000.

Within this framework, efforts to strengthen implementation of the IMCI strategy will translate into better health conditions for the children of the Hemisphere, giving them equitable access to adequate health care through the health services as well as the family and community. Some of the obstacles to achieving implementation of the IMCI strategy are listed below:

- ***Effective incorporation of the IMCI strategy in the health sector reform processes*** currently under way in the countries is a high priority, not only to help implement the strategy in the health system but, especially, to guarantee equity and efficiency in health care for children throughout the country’s health structure, both public and private. Application of the IMCI strategy in health care

for children under 5 guarantees them same safe access to a series of measures for the early detection and proper management of illness, in addition to disease prevention and health promotion activities that are rarely part of a routine consultation, not only in the public health services but the private health services and social security institutions as well.

- The ***commitment of the countries to support the implementation effort*** is essential, bearing in mind the time that will be needed to ensure that all health services and health workers are in a position to apply the IMCI strategy. This requires training, the steady provision of the necessary supplies for conducting the activities (especially antibiotics and other drugs for treatment), periodic supervision to ensure the effective application of the strategy, and communication about the IMCI strategy in order to transfer knowledge and positive attitudes to the community responsible for the child. Effective incorporation of the implementation plans in the budgets of the ministries of health, an explicit commitment by the governments to achieve the goals of reducing mortality and morbidity, and improving the quality of health care for children, together with periodic reporting on the progress in this regard can serve as a tool for the mobilization of resources and participation by the population in caring for and protecting the health of children. In this regard, the example set by the Dominican Republic in adopting a National Integrated Management of Childhood Illness Day, in which the government publicly reports on the progress made in the implementation of this strategy, can serve as a model for the adoption of similar mechanisms to encourage greater participation by the population in monitoring the actions and outcomes of health interventions.

- ***Effective introduction of the IMCI strategy in the training of health workers*** is a major challenge aimed at reducing the burden imposed by the ongoing training of staff in activities to control the most frequent illnesses and health problems that affect the community. Teaching the strategy in academic institutions will elicit greater support for its implementation, while reducing the workload and the additional costs entailed by the training. It will shorten the time frame for implementation and increase access in the health services manned by personnel from the universities, medical schools, and schools of nursing.

- ***Bolstering the active participation of NGOs in the implementation*** of the IMCI strategy will help to extend coverage for the population that can receive its benefits, especially through community workers who share in the planning and activities of these institutions. Thus, it will facilitate the transfer of the necessary knowledge and practices to the population, guaranteeing better health conditions for children.

- ***Adaptation of the IMCI strategy for application to different epidemiological situations*** that give priority to other components of child health, including the monitoring of growth and promotion of development and the prevention of accidents and child abuse, also poses a significant challenge for linking the health services with the reality of each place. Incorporating the components that link the IMCI strategy with other components of family health care, such as perinatal care, reproductive health, women's health, and family health, will help to reduce missed opportunities for the early detection and treatment of problems, as well as disease prevention and health promotion in the community.

8. Action Required of the Subcommittee on Planning and Programming

The Subcommittee is requested to review the present document and offer its input, particularly with respect to the challenges that must be faced. It is also requested to formulate observations and recommendations on the progress made in implementing the IMCI strategy in the Region of the Americas in terms of achieving the goals of reducing child mortality and morbidity and improving the quality of health care for children in the health services and the community.

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