



## Virtual Meeting Report:

# STRENGTHENING AND SCALING UP IMCI IMPLEMENTATION IN THE CONTEXT OF QUALITY-OF-CARE INITIATIVES

February 8–9, 2023

## LESSONS LEARNED FROM BANGLADESH, GHANA, MALAWI, SIERRA LEONE

The U.S. Agency for International Development (USAID) MOMENTUM Country and Global Leadership project organized a virtual meeting on 8–9 February 2023 (2.5 hours each day) to review progress in strengthening and scaling up integrated management of childhood illnesses (IMCI) implementation in the context of quality-of-care initiatives in Bangladesh, Ghana, Malawi, and Sierra Leone.

**The 39 participants** included policymakers, program managers, implementers, technical experts from the ministries of health (MOHs) of Bangladesh, Ghana, Malawi, and Sierra Leone and global, regional, and national partners focusing on child health, IMCI, pneumonia, and possible severe bacterial infection (PSBI). See Annexes for meeting concept note, agenda, and subsequent chat by participants.

## SUMMARY OF PRESENTATIONS AND DISCUSSION

The virtual meeting consisted of a series of global and country presentations, with plenary discussions. The meeting was guided by its three objectives:

- Share updates on status of IMCI implementation and best practices from participating countries (Bangladesh, Ghana, Malawi, and Sierra Leone)
- Identify major barriers impeding further progress (based on the IMCI assessment study)
- Recommend actions for overcoming barriers and operationalizing IMCI implementation at scale



## STATUS OF IMCI IMPLEMENTATION AND BEST PRACTICES

### A DESK REVIEW IDENTIFIED MAJOR CHALLENGES AND ENABLERS

The [IMCI desk review](#) commissioned by MOMENTUM in 2021 identified major challenges and enablers for IMCI implementation from a health systems perspective. The review analyzed common themes in the domains of service delivery, quality of case management, medical technologies and supplies, health information systems, leadership and governance, and human resources. The review highlighted that health system challenges, such as stock-outs of essential commodities for child health, lack of supportive supervision and skills reinforcement, weak referral systems, lack of incentives and motivation, high turnover of trained staff, and inadequate human and financial resources, were major barriers to further progress in IMCI implementation.

### ADHERENCE TO IMCI GUIDELINES IS LOW

A study conducted by the USAID-supported SHOPS Plus (Sustaining Health Outcomes through the Private Sector) project used service provision assessment (SPA) data from public and private health facilities in seven countries to examine how well these facilities adhered to IMCI guidelines. SPAs, including sick-child visit observations, were conducted in Afghanistan, Democratic Republic of the Congo, Haiti, Malawi, Nepal, Tanzania, and Senegal (2013–2019). The analysis showed that adherence to individual diseases/conditions in IMCI guidelines was less than 50%, and overall adherence to all conditions in IMCI guidelines was less than 0.1%. Adherence was lowest when assessing for danger signs, HIV infection, and acute malnutrition. For newborns and young infants it was lowest when checking for very severe disease and local bacterial infection. The analysis also revealed that providers at public and private facilities differed in their level of adherence, with private providers performing slightly better (compared to health care providers in public sector) in managing cough and fever, while public sector providers did better (than private providers) in checking for immunization status and asking questions on diarrhea.

### UNDERSTANDING HEALTH CARE PROVIDERS' MOTIVATION AND DEVELOPING APPROPRIATE STRATEGIES TO ADDRESS IT

MOMENTUM facilitated a session during the virtual meeting on provider's behavioral barriers and aspects in effective IMCI implementation. Provider behavior is a complex outcome of both internal and external factors, including providers' attitudes, values, beliefs; their access to professional development for building skills, confidence, and problem-solving ability; the supervisory support they receive; and a supportive workplace environment. Provider behavior may also be a function of strength and functionality of their health system (e.g., supportive supervision, availability of commodities) along with acceptance/recognition and support from the community and caregivers. Therefore, it is essential to understand the ecosystem in which providers work and identifying the factors that impact their behaviors, including those of other actors in the system (supervisors, government staff, logistics managers, community member/caregiver, etc.). Providers' poor motivation and poor adherence needs immediate analysis and attention and should be taken into account for further planning and strategy setting for effectively strengthening and scaling up IMCI implementation. Additionally, understanding provider behavior as one component of pediatric quality-of-care directly relates to the experience of care; therefore, indicators relating to experience-of-care should not be limited to just the client's perspective but also should account for providers' behavioral analysis.

## COUNTRY UPDATES ON IMCI IMPLEMENTATION

In **Bangladesh**, the MOH introduced IMCI in 2002 and achieved country-wide coverage with strong collaboration among government and non-government organizations, professional bodies, development partners, and the private sector. In 2015, PSBI was included in the IMCI strategy and in January 2017, Directorate of Health Service (DGHS) renamed the then-IMCI section as the National Newborn Health Program and IMCI Program. IMCI has been integrated into the pre-service curriculum of medical, paramedical, and nursing students. Implementation research on facility and community IMCI has provided guidance to policymakers and program staff on how best to implement and scale up IMCI implementation. The updated 2019 IMCI guidelines were adopted in Bangladesh in 2020.

In **Ghana**, IMCI activities are overseen by the Newborn and Child Health program, which is housed in the Family Health Division. The division is part of the Ghana Health Service, an agency of Ghana's MOH, and responsible for provision of health services at public facilities and public health activities throughout the country. Although progress has been made in integrating IMCI into the curriculum of the College of Health and Wellbeing, where physician assistants are trained, only 11 districts out of the 261 districts in five regions are implementing IMCI due to inadequate numbers of trainers and supervisors and weak collaboration between IMCI and other components in the Newborn and Child Health program (e.g., immunization, nutrition and water, sanitation, and hygiene [WASH]), including training institutions.

**Malawi** officially introduced IMCI as a strategy in 1999; in 2001 integrated management of newborn and childhood illnesses (IMNCI) (addressing newborn within IMCI) was officially integrated into national health policy and guidelines and efforts were made to expand its implementation to all health facilities across the country. The government leadership, in formulating appropriate policies for child health and establishing a government structure (a technical working group at national level) that promotes coordination and facilitates alignment and uptake of updated technical guidelines, tools, and implementation approaches, has contributed to wide-scale IMCI implementation. Currently, 50% of health workers at the primary health center level have been trained on IMCI, while 70% of health facilities have at least one health worker trained on IMCI.

In **Sierra Leone**, with the introduction of IMCI in 2001, trained health care providers started providing support for the implementation of IMCI (estimated 20%–60% public facilities had only one IMCI-trained provider). The revised IMCI guideline was adapted in Sierra Leone in 2016 and, to emphasize newborns within IMCI, the country decided to rename it as IMNCI. Following another round of updates for PSBI in 2019, the country adapted the updated version in 2020. However, a health facility survey conducted in 2022 revealed gaps in health providers' management of sick children. To address these gaps, a strategy focusing on the provision of supportive supervision and mentorship was developed and is being implemented. Well-trained supervisors provide high-quality mentorship to facility-level providers; the use of a digital tool (phone-based KoboCollect) for supportive supervision and mentoring has greatly improved the ease of supervision, timeliness, and completeness of performance data and reporting.

The reviews and country updates shed light on the various factors that can contribute to the improvement of the current status of IMCI implementation. Several enabling factors have been identified, including strong government leadership, as evidenced by Malawi's successful integration of IMCI into their national child health strategies, and inter-program support that fosters service integration and harmonization.

Innovations and digitalization, such as those implemented in Sierra Leone and Bangladesh, have also presented opportunities for addressing challenges related to data and supervision. In Ghana, the introduction of IMCI in pre-service institutions can significantly contribute to capacity-building efforts and the promotion

of IMCI standards of care. Furthermore, Global Fund and World Bank country projects provide opportunities to support IMCI-related activities, both at the facility and community levels.

By capitalizing on these enabling factors and opportunities, countries can improve the implementation of IMCI and ultimately enhance the health outcomes of children.

## BEST PRACTICES AND LESSONS LEARNED

In Bangladesh, the national IMCI working group has been activated through strong collaboration among government and non-government organizations, professional bodies, and development partners to ensure enhanced management of childhood pneumonia by community health workers at community clinics. Bangladesh's MOH representatives emphasized using devices and tools (for example: pulse oximeter, digital auscultation, and clinical decision-support application supporting IMCI algorithm), inclusion of IMCI protocol in medical, paramedic and nursing curriculum, and establishing an effective and functional referral system as potential beneficial steps in coming days. Ghana MOH continues to work with former IMNCI care providers and experts who are no longer in active service to coach, mentor, and share knowledge and skills with existing and upcoming staff in IMNCI. Ghana is also mapping out a strategy to support pre-service IMNCI case management training, emphasizing the building of pools of IMNCI facilitator and supervisor at national and regional levels, and developing master trainers at zonal level. Malawi successfully introduced training of health care workers on IMNCI. Improved quality of service delivery and access to primary health care levels resulted in increased number of sick children attending facilities. Malawi's MOH also ensured availability of oxygen at selected facilities and facilitated improvement of pneumonia case management after the COVID-19 pandemic. In Sierra Leone, IMCI-trained providers often cascade knowledge with untrained colleagues using IMNCI booklets.

## MULTI-COUNTRY IMCI ASSESSMENT IDENTIFIED MAJOR BARRIERS IMPEDING FURTHER PROGRESS AND POTENTIAL SOLUTIONS/BEST PRACTICES

Country presenters summarized challenges and potential solutions and/or best practices specific to their countries. These presentations were informed by results from MOMENTUM’s qualitative study for assessment of barriers and enablers of IMCI implementation and scale-up opportunities. The barriers and solutions discussed during the meeting are captured in the table below. *(Note: while there are many barriers and solutions to IMCI adaptation and scale-up, this meeting report captures only those which were highlighted and discussed in the meeting itself.)*

Barriers	Solutions
<b>Unavailability of trained IMCI provider</b>	<ul style="list-style-type: none"> <li>Integrate IMCI into pre-service curriculum of medical and paramedical institutions.</li> <li>Develop a pool of national and regional level IMCI facilitators and supervisors (including staff from malaria program, immunization, institutional care, and the training institutions as well as experts/specialists from professional bodies, for example, associations or forum of pediatricians, neonatologist, nurse).</li> </ul>
<b>Lack of regular refresher training</b>	<ul style="list-style-type: none"> <li>Introduce a training calendar including a tracker.</li> <li>Institutionalize post training follow-up/ mentoring.</li> <li>Introduce digital supportive supervision and mentoring/coaching as a potential approach to ensure continued training and maintaining performance of providers.</li> </ul>
<b>Low adherence to IMCI protocols (steps and guidelines) for assessment, classification, and treatment</b>	<ul style="list-style-type: none"> <li>Address issues related to supply chain and procurement related issues.</li> <li>Include case observation during supervisory visits.</li> <li>Analyze and address providers’ behavior (explained further under “key takeaway messages” below).</li> </ul>
<b>Weak referral and follow-up system</b>	<ul style="list-style-type: none"> <li>Strengthening monitoring and supervision.</li> <li>Identify options for improving coordination between referral points and community health centers.</li> <li>Increasing targeted social behavioral change activities for families and communities about timely care-seeking and the importance of adherence/acceptance to referral recommended by the provider.</li> </ul>
<b>Supplies and commodities for IMCI services: insufficient quantity, lacking availability</b>	<ul style="list-style-type: none"> <li>Decentralization of drug procurement and distribution of drugs and supplies to the district/ county level: allow district health officers to procure from private providers along with central medical stores to avoid stockouts. To avoid service interruption, it is critical for decisions by district health officers to replenish drugs and supplies to facilities/providers based on local need.</li> <li>Closely monitor and support electronic logistics management information systems.</li> </ul>
<b>Partner-driven funding choices on interventions</b>	<ul style="list-style-type: none"> <li>Advocate and communicate with partners and donors to support one implementation plan based on country priorities.</li> </ul>
<b>Top-down system and structure</b>	<ul style="list-style-type: none"> <li>Support decentralization and bottom-up approach in terms of supply and distribution of medicines and equipment.</li> <li>Allocate local budget and ensure the local-level capacity for purchase of critical equipment and supplies.</li> <li>Ensure an effective quality improvement process, coordinated data management, and reporting of programs.</li> <li>Strengthen local-level participation by making the health management committee and other stakeholders more aware and effective.</li> </ul>

## KEY TAKEAWAY MESSAGES

### ADDRESS HEALTH SYSTEMS ISSUES INFLUENCING PROVIDERS' ADHERENCE TO IMCI GUIDELINES

Health care providers' adherence to IMCI is dependent on multiple systems factors, not all of which are within providers' control. Thus, there is a need to look at broader health system issues that address common barriers and, at the same time, examine their work environment and patient load with clients and providers working in a participatory manner to identify bottom-up and local solutions. Additionally, for developing strategies to improve providers' adherence to IMCI guidelines, it is necessary to apply a behavioral lens that considers providers, their constraints, and their motivations.

### HEALTH CARE PROVIDER PERFORMANCE NEEDS SUPPORT AND STRENGTHENING

While in-service training has been a major focus of IMCI implementation in many countries, the current training approaches are not always systematic or optimized, therefore strengthening pre-service training was raised by participants as one high-value dimension that requires attention. In addition, mentoring/coaching and supervision of IMCI-trained providers are significant challenges that need urgent attention and innovative solutions. Regular monitoring and evaluation of health care provider performance using standard quality-of-care indicators was also emphasized by participant country teams as necessary to improve and sustain performance.

### INNOVATIONS ARE ESSENTIAL FOR SCALING UP IMPLEMENTATION

The Enhanced Management of Pneumonia In Community (EMPIC) study results in Malawi and Bangladesh revealed that community-level health workers successfully performed pulse oximetry and treated non-hypoxemic children (2–59-month-old) (children with low oxygen levels) with chest-indrawing pneumonia with oral amoxicillin. Another study on using digital auscultation technique by community health workers in Bangladesh was mentioned; the results demonstrate the usefulness and feasibility of using a novel digital diagnostic tool for identifying children with pneumonia. In Sierra Leone, recent efforts to align sick-child registers with IMCI guidelines (following the IMCI chart booklet) were effective in enhancing IMCI providers' adherence to the IMCI protocol itself, which facility-level providers valued greatly. Bangladesh also reported similar alignment of sick-child register to the IMCI guidelines and noted the positive benefits. Ghana shared their positive feedback from providers, specifically on improving quality of care, after introducing pre-service training and initiating pools of mentors and coaches from experienced IMCI service providers and experts.

Given these experiences on innovative initiatives and research results, the participant country representatives emphasized the need to further advance innovations, including implementation and operations research, such as the use of digital platforms/solutions to address better adherence to standard guidelines, improve data recording and reporting, use data to make decisions and to plan, and improve quality of care.

## ACTION FOR OPERATIONALIZING IMCI AT SCALE

Given the critical importance of operationalizing IMCI effectively at scale for accelerating reductions in under-five mortality, the meeting participants reiterated the urgent need for action to achieve 2030 child survival goals, especially in the 54 countries not on track to achieve the under-five mortality target. IMCI, integrated into pediatric quality of care, has the potential to address common causes of child morbidity and mortality; but, addressing the strengths and weaknesses identified in the meeting is necessary to achieve this potential.

This meeting provided opportunities for cross-learning and dissemination of best practices regarding IMCI implementation. However, while some countries have successfully scaled up IMCI, others have limited coverage due to health system challenges. Within the broad objective of institutionalizing IMCI at scale, one area that emerged as a key next step was digging deeper into the barriers and challenges to understand how we can improve providers' adherence and compliance to IMCI protocol and improve scale-up of IMCI, with a specific focus on behavioral challenges considering the whole provider ecosystem.

Based on shared country experiences, effective IMCI implementation at scale requires sustained MOH leadership and technical working groups in place to guide implementation and facilitate coordination and integration of relevant programs (such as nutrition, WASH, immunization, malaria, HIV control). Partners represented in the meeting committed to redoubling of efforts to support countries in scaling up effective IMCI implementation and optimizing the use of resources focused on accelerating progress in child survival.



## ANNEX 1: CONCEPT NOTE

### STRENGTHENING AND SCALING UP IMCI IMPLEMENTATION IN THE CONTEXT OF QUALITY-OF-CARE INITIATIVES: LESSONS LEARNED FROM SIERRA LEONE, MALAWI, GHANA, AND BANGLADESH

#### BACKGROUND

Globally, 5 million children under the age of five were estimated to have died in 2020 (UN IGME Child Mortality Report 2021). Infectious diseases continue to be a leading cause of death for children under-5 with pneumonia, diarrhea, and malaria as the top three leading causes of death (28% of all under-five deaths collectively) in children 2–59 months of age and pneumonia and sepsis among young infants (0–59 days) (UN IGME, 2019). Effective, safe, and low-cost lifesaving interventions are available, with integrated management of childhood illnesses (IMCI) as proven strategy to deliver the interventions. In the absence of any alternate mechanism, countries still consider IMCI as an important and effective mechanism to deliver lifesaving interventions (Costello & Dalglish, 2016; Pradhan, Rizvi, Sami, & Gul, 2013). Since its introduction in 1995, the generic World Health Organization (WHO)/UNICEF IMCI guideline has gone through a number of adaptations and updates. The scope has also increased over the years with the most recent introduction of management of sick young infants with possible serious bacterial infection (PSBI) where referral is not possible. The 2019 WHO/UNICEF IMCI guidelines for management of sick young infants (under 2 months old) recommend that when referral is not possible, young infants with PSBI should be treated on an outpatient basis. The implementation of these guidelines at country level has the potential to drastically improve access to treatment for sick young infants.

Although significant progress has been made in generating the evidence and making available appropriate guidelines and tools, universal access to and delivery of quality care for children and infants presenting with the most common illnesses remains a challenge. One of the contributing factors is the long delay in the adoption and dissemination of updated guidelines at country level and subsequent operationalization at subnational, facility, and community levels.

Although a number of countries have revised their 2014 IMCI guidelines for pneumonia case management, only 40% of countries in the African Region, 45% in South East Asia, and 27% in Eastern Mediterranean Region have policies aligned to 2014 IMCI pneumonia guidelines (WHO, 2018). Even in countries that have adopted the 2014 IMCI guidelines, overall quality of case management, including pneumonia case management, remains poor. Adherence to case management protocol at service-delivery level is equally poor. Studies have shown that counting of respiratory rate by providers is very low, leading to incorrect diagnosis of pneumonia (Bjornstad et al., 2014; Uwemedimo et al., 2017; Izudi, Anyigu, & Ndungutse, 2017). Instead of following IMCI protocol, providers focus on single diseases, especially fever, contributing to poor assessment for pneumonia and over and under prescription of antibiotics (Acacio et al., 2015; Johansson et al., 2016; Uwemedimo et al., 2017). A study from South Sudan found that only 10% of providers adhered to all the steps of the IMCI guidelines when managing children presenting with cough or difficult breathing (Izudi, Anyigu, & Ndungutse, 2017). A study from Sindh province in Pakistan found that only 2% of providers assessed for all signs of PSBI in young infants (Bhura et al., 2020). These study findings demonstrate the need for reinforcing the importance of adherence to IMCI protocol. Multiple studies have also looked at reasons for weak implementation of IMCI guidelines. Common barriers identified for weak implementation of IMCI include: weak training, especially skills training; poor motivation and low confidence of providers in adhering to IMCI guidelines; lack of refresher training; lack of supervision and mentoring; lack of awareness, leadership, and ownership at district level; and finally, lack of a focus on provider training and strategic planning. There is a need to strengthen all aspects of the health system (Pradhan et al., 2013; Lange, Mwisongo, & Maestad, 2014; Tshivhase, Madumo, & Govender, 2020;



Adekanye & Odetola, 2014; Seid & Sendo, 2018; Titaley et al., 2014; Pandya, Slemming, & Saloojee, 2018). A 2022 USAID-supported MOMENTUM Country and Global Leadership desk review report on “Barriers and Enablers of IMCI Implementation” summarized the key findings of this body of work from a health systems perspective, summarizing common themes in the domains of human resources; medical technologies and supplies; health information systems; leadership and governance; and service delivery.

Expanding alignment with the updated IMCI guidelines and building capacity at all levels of the health system to operationalize it is critical to achieving the Sustainable Development Goals (SDGs) and child survival targets. Strengthening the overall IMCI platform will also improve the coverage and quality of PSBI, management of fever, diarrhea, malnutrition, and immunization services. It will also improve nutrition counselling and young child feeding during and after the illness episode.

MOMENTUM Country and Global Leadership, along with other partners, have been supporting a number of countries including Bangladesh, Ghana, Malawi, and Sierra Leone in implementing and scaling up IMCI as part of the overall quality-of-care initiative. Most recently, a qualitative study has been conducted in these countries to assess barriers and enablers to IMCI implementation, which included key informant interviews with decision-makers and implementers at the national and district levels and health care providers from first-level health facilities and community. The findings from these assessment studies provide valuable insight into status of IMCI implementation and issues that need to be addressed for countries to improve and strengthen implementation in their efforts to achieve the SDGs for child health.

The MOMENTUM Country and Global Leadership project is hosting a meeting that will bring these selected countries together to take stock of progress, share perspectives, successes and best practices, barriers for implementation at scale, and potential solutions. International, regional, and national partners focusing on IMCI, pneumonia, and PSBI, as well as MOH staff from these countries, will be invited to the meeting. The meeting will provide opportunities for cross-learning and dissemination of lessons learned and best practices.

**The objectives of this meeting are to:**

1. Share updates on status of IMCI implementation and best practices
2. Identify major barriers impeding further progress
3. Recommend actions for overcoming barriers and operationalizing IMCI implementation at scale

**Expected outcome**

1. Update on status of IMCI implementation in each country
2. Best practices and lessons learned identified
3. Major barriers identified and recommendations for overcoming barriers and operationalizing IMCI at scale agreed upon
4. Priority actions at country level (and specifically by country) to address key barriers and strengthen IMCI implementation identified

**Proposed dates, platform, and administrative support**

- Dates: 8–9 February 2023, 12:00–14:30 UTC each day
- Platform: Zoom
- This meeting will be sponsored and administered by the USAID-funded MOMENTUM project. The virtual meeting will extend invitation to WHO, UNICEF, MOMENTUM, and Child Health Task Force

## **Method of Work**

The virtual meeting will consist of a series of plenary country presentations and discussions. The meeting will provide an opportunity for cross-learning and sharing of best practices. Partners and experts in the field of IMCI, pneumonia, and PSBI will engage in the dialogue and discussion to contribute to the final recommendations and development of a strategy for action.

## **DAY 1 (2.5 HOURS)**

**Objective:** Share updates on status of IMCI implementation, best practices and barriers

- Opening session (include objectives of meeting): remarks from MOMENTUM, USAID – 15 minutes
- Introduction of participants – 10 minutes
- Remarks from UNICEF and WHO – 15 min
- Country update on IMCI implementation – 15 minutes for each country presentation with 5 minutes for questions/clarification for each country (80 minutes)
  - Bangladesh
  - Ghana
  - Malawi
  - Sierra Leone
- Analysis of adherence to IMCI guidelines in public and private facilities (SHOPS [Sustaining Outcomes through the Private Sector] plus service provision analysis on sustaining outcomes through the private sector) – 20 minutes
- Review of Day 2 agenda – 10 minutes

## **DAY 2 (2.5 HOURS)**

**Objective:** Identify priority actions to address key barriers and strengthen IMCI implementation

- Summary from Day 1 – 15 minutes
- Addressing health care providers' adherence to standard guidelines, presentation by Christina Wakefield – 20 min, including Q&A
- Presentation from each country on specific actions for overcoming barriers (10 minutes for each country)
  - Bangladesh
  - Ghana
  - Malawi
  - Sierra Leone
- Plenary discussion – 30 min
- Panel discussion – 25 min
- Conclusion and wrap up – 10 min

## ANNEX 2: MEETING AGENDA

Day 1: February 8, 2023, 12:00 - 14:30 UTC. Facilitator: Samira Aboubaker		
12:00–12:20	<p>Opening remarks, introduction of participants, activity history, and objectives</p> <p>Welcome and opening remarks session (includes objectives of meeting), background presentation</p>	<p>Samira Aboubaker, John Borrazzo, and Rashed Shah</p> <p><i>MOMENTUM Country and Global Leadership</i></p>
12:20–12:35	<p>Remarks from partners</p> <p>Remarks from USAID, WHO, and UNICEF (5 min per partner)</p>	<p>Joseph Monehin <i>USAID</i></p> <p>Bernadette Daelmans <i>WHO</i></p> <p>Anne Detjen <i>UNICEF</i></p>
12:35–14:00	<p>Country update on IMCI implementation</p> <p>Country Presentation (15 minutes per country)</p> <ul style="list-style-type: none"> <li>Bangladesh</li> <li>Ghana</li> <li>Malawi</li> <li>Sierra Leone</li> </ul> <p>Discussion including Q&amp;A on presentations</p>	<p>Dr. Muhammad Shariful Islam <i>Line Director, MNCAH program and Program Manager of Newborn and IMCI program, Ministry of Health and Family Welfare, Bangladesh</i></p> <p>Grace Eddy Amewu <i>Program Officer for IMNCI and School Health, Ghana Health Service</i></p> <p>Humphreys Nsona <i>Program Manager, IMCI Unit, Ministry of Health, Malawi</i></p> <p>Lynda Farma-Grant <i>Deputy Health Program Manager, Child Health and EPI, Ministry of Health and Sanitation, Sierra Leone</i></p>
14:00–14:20	<p>Analysis of Adherence to IMCI guidelines in public and private facilities</p> <p>Presentation and discussion (SHOPS Plus [Sustaining Outcomes through the Private Sector])</p>	<p>Tess Shiras <i>Abt Associates</i></p>
14:20–14:30	<p>Review of Day 2 agenda</p> <p>Facilitator to summarize day 1 and review day 2 agenda</p>	<p>Samira Aboubaker <i>MOMENTUM Country and Global Leadership</i></p>

Day 2: February 9, 2023, 12:00 - 14:30 UTC. Facilitator: Samira Aboubaker		
12:00–12:10	<b>Summary from Day 1</b> Synthesis/highlights from day one	Rashed Shah <i>MOMENTUM Country and Global Leadership</i>
12:10 –12:35	<b>Addressing health providers behavior</b> Presentation and discussion Addressing health care provider’s adherence to standard guidelines	Christina Wakefield <i>MOMENTUM Country and Global Leadership</i>
12:35–13:35	<b>Actions for overcoming barriers</b> Country Presentation on specific actions for overcoming barriers (10 minutes per country) <ul style="list-style-type: none"> <li>• Bangladesh</li> <li>• Ghana</li> <li>• Malawi</li> <li>• Sierra Leone</li> </ul> Discussion including Q&A on presentations	Dr. Muhammad Shariful Islam <i>Line Director, MNCAH program and Program Manager of Newborn and IMCI program, Ministry of Health and Family Welfare, Bangladesh</i>  Grace Eddy Amewu <i>Program Officer for IMNCI and School Health, Ghana Health Service</i>  Humphreys Nsona <i>Program Manager, IMCI Unit, Ministry of Health, Malawi</i>  Lynda Farma-Grant <i>Deputy Health Program Manager, Child Health and EPI, Ministry of Health and Sanitation, Sierra Leone</i>
13:35–14:00	<b>Overcoming barriers</b> Panelists from UNICEF, WHO, USAID, discuss options for overcoming barriers impeding further progress	Moderator: John Borrazzo <i>MOMENTUM Country and Global Leadership</i>
14:00–14:30	<b>Takeaways</b> Next steps	Samira Aboubaker <i>MOMENTUM Country and Global Leadership</i>
14:30	<b>Closing</b>	Rashed Shah <i>MOMENTUM Country and Global Leadership</i>  Joseph Monehin <i>USAID</i>

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