# Table of contents

1. Introduction ........................................................................................................................................... 3
2. Overview of the IMCI strategy .............................................................................................................. 4
3. Rationale for introducing IMCI in Cambodia .......................................................................................... 7
4. Principles for Implementation of IMCI ................................................................................................. 9
5. Overview of the Early Implementation Phase of IMCI ....................................................................... 13
6. Improving health worker skills through IMCI .................................................................................... 15
7. Improving the health system ................................................................................................................ 19
8. Improving family and community practices ....................................................................................... 19
9. Management of IMCI ........................................................................................................................... 19
12. Budget .................................................................................................................................................. 21
13. Monitoring and evaluation .................................................................................................................. 21

Annex II. Workplans 1999-2000 ............................................................................................................. 23
Annex III. Terms of reference and membership of IMCI working group and sub-groups ..................... 23
Annex IV. Criteria for selection of pilot operational districts .................................................................... 33
Annex V. List of participants at the IMCI Planning Workshop - October 1998 ........................................ 34
1. INTRODUCTION

The health status of Cambodia's children is one of the worst in the world with more than one out of nine children dying before their fifth birthday\(^1\). The direct effects of a high disease burden and widespread malnutrition, the indirect effects of poor maternal health, limited availability of basic health services and poor household health knowledge result - in almost 40,000 under-five child deaths each year\(^2\).

The main direct causes of child illness and death are diarrhoeal diseases, acute respiratory infections and vaccine preventable diseases, particularly measles, which are together estimated to be responsible for over half of all child deaths. Severe malnutrition compounds the effects of these illnesses and results in the heavy death toll. Deficiencies in micronutrients - including vitamin A, iron and iodine - are widespread and considered to be significant public health problems. In limited geographic areas dengue fever and malaria are significant causes of child morbidity and mortality.

One third of child deaths in Cambodia occur during the first month of life\(^3\). The poor health status of Cambodian mothers - including widespread anemia - and lack of access to maternal health services are vital factors contributing to child morbidity and mortality as a result of poor maternal health, inadequate prenatal care, poor delivery practices and management of delivery complications as well as poor care of the new born. Rapidly increasing rates of HIV infection in pregnancy now results in an increased number of HIV infected children due to maternal-child transmission of the virus, this year alone about 3,000 of an estimated 10,000 children born from HIV positive mothers\(^4\).

While the pattern of childhood diseases is similar to that in other low income developing countries, Cambodia's children are especially vulnerable because of their combined impact, the severity of the underlying malnutrition and the limited capacity of the health system to respond or to prevent.

Child malnutrition in Cambodia is significant, affecting over half of all children under five years of age. The contribution of protein-energy malnutrition (PEM) to under-five child mortality in Cambodia is estimated to be as much as 77\(^5\). A national survey in 1996 showed that 53% of Cambodian children are malnourished, 17% severely\(^6\). Malnutrition rates are highest in the rural population which makes up over 80% of the child population. Causes are complex and multifactorial. The problem appears to start early on in life as, a result of high maternal malnutrition and low birth weight, Reasons for poor maternal nutrition in pregnancy are both cultural (restricting food intake during pregnancy) and economic (food security). In the young child, feeding and poor child caring practices appear to be major factors contributing to the extent of the problem.

Progress to address this situation is being made. Major policies and plans for improving health services and child survival and development are now in place. The Government ratified the Convention on the Rights of the Child in 1992 and committed itself in 1993 to achieving the World Summit Goals for children.

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\(^1\) The National Health Survey 1998 (NHS 1998) indicates an infant mortality rate (IMR) of 90/1,000 live births and an under-five mortality rate (U5MR) of 115/1,000 live births.

\(^2\) Number of estimated child deaths based on Population (National Census 1998) x Crude Birth Rate (NHS 1998) x U5MR = 11,400,000 x 29/1,000 x 115/1,000 = 38,100

\(^3\) Neonatal mortality rate 36/1,000 live births (NHS 1998)

\(^4\) Estimated prevalence of HIV positive pregnant women x population x CBR x vertical transmission rate = 3.4% x 11,400,000 x 29/1,000 x 300/6 (figures based on MOH Sentinel Surveillance System)


- Primary health care approach;
- Extending and improving basic health services at the district and commune level;
- Ensuring the supply and good use of essential drugs;
- Control of communicable diseases;
- Increased attention to health education, disease prevention and curative care especially for the rural population.


Safe Motherhood policy and strategies were adopted in 1997 and several components - especially birth spacing activities and development of treatment protocols for health workers - are being implemented under the leadership of the National MCH Centre.

Following an inter-ministerial workshop on Primary Health Care (PHC) in February 1997, national PHC policies are being developed under the leadership of the National Centre for Health Promotion (NCHP).

Several National Programs have in addition developed policies for their areas of responsibility - including CDO/ARI/Cholera, EPI, malaria, dengue fever and vitamin A supplementation. The Essential Drugs Bureau has in cooperation with several partners produced national essential drug lists for the different levels of care.

Other ministries than the MOH are involved with child health issues and are important partners in planning and implementing IMCI activities. This includes the Ministry of Rural Department (MRD), the Ministry of Womens’ Affairs (MOWA) and the Ministry of Education, Youth and Sports (MEYS).

The development of a National Plan for the Early Implementation of IMCI reaffirms the Ministry of Health's commitment to promote survival and improve the health and lives of Cambodian children.

2. OVERVIEW OF THE IMCI STRATEGY

Integrated Management of Childhood Illness - what it is

Every year more than 11 million children in developing countries die before the age of five, many during their first year of life. Seven in ten of these deaths are due to conditions that in general are preventable or curable: acute respiratory infections (mostly pneumonia), diarrhoea, measles, malaria or malnutrition - often in combination.

Much has been learned from disease-specific child survival programmes in the past 15 years. The challenge now is to apply the lessons from these programmes to coordinated and integrated strategies that will improve the prevention and management of childhood illness.
The World Health Organization (WHO), UNICEF, the World Bank and numerous other agencies have responded to the challenge by developing the Integrated Management of Childhood Illness (IMCI) strategy.

Using a set of interventions for integrated treatment and prevention of major childhood illnesses, the IMCI strategy aims to reduce death and the frequency and severity of illness and disability, and to contribute to improved growth and development of children. It is considered by the World Bank as one of the most cost-effective health interventions in countries with child mortality rates of more than 30 per 1,000 live births.

The IMCI strategy is not a new vertical programme with a new set of health interventions and it is not intended to replace existing national programmes. It is a primary health care strategy targeting children and their caretakers, integrating and coordinating the efforts of existing programmes and activities, and focusing both on health facilities and on families and communities.

The IMCI strategy has three main components:

Component 1: Strengthening skills of health workers

The first component consists of adapting the generic WHO/UNICEF 11-day training course and conduct training of first-level health workers. Aimed at improving quality of care for sick children, the IMCI standard case management protocols are a simplified system of diagnosis and treatment designed for use by health workers with limited training and with little or no laboratory support. The testing and validation of guidelines has shown them to be both sensitive and specific when compared to a physician’s diagnosis using laboratory tests and radiographs.

The IMCI strategy can be used both for in-service and pre-service training of health professionals and can as well be considered for health providers in the private sector.

Research is being conducted to further improve the guidelines, including detection and classification of anemia and to increase the specificity, of hospital referral. This core intervention builds on integrated case management of the six most important childhood illnesses (acute respiratory infections, diarrhea, malaria, measles and malnutrition - and dengue hemorrhagic fever for Cambodia), -improved -nutritional counseling of care-takers, better follow-up of sick children and promotion of preventative interventions.

Component 2: Improving the health system

With on-going Health Sector Reform activities aimed at improving and extending primary health care through a district based health system, the second component of the IMCI strategy is already well on track in Cambodia. By increasing the quality of health services and providing a concrete content to health system re-structuring, the IMCI will support and complement health sector reforms. Issues to be addressed include planning and monitoring, training strategies, management of health centres, supervision, referral systems and drug supply systems.

Component 3: Improving family and household practices

The third component, "Community-based IMCI", has emerged as a realization that improved health services alone will not substantially reduce child morbidity and mortality. Because most child deaths occur outside of the health facility, families and communities are key partners having the main responsibility for their children’s good health and development. Adequate home case management of sick children, timely and appropriate care-seeking and follow-up,
improved nutritional practices and community involvement in health services are the most important elements of IMCI in the community.

**Global overview**

The IMCI strategy is in general planned and implemented in three phased manner:

? The introduction phase - which includes orientation, MOH endorsement and establishment of an IMCI management structure.

? The early implementation phase - which includes adaptation and preparation of IMCI protocols and guidelines, training of national and district level facilitators, planning, test implementation (including health worker training) and evaluation of interventions in some few pilot districts.

? The expansion phase - with expansion of geographic coverage and activities.

Although only initiated in 1994, the response from ministries of health has been impressive. By August 1998:

? 20 countries had started introducing the IMCI.
? 25 countries had entered the early implementation phase.
? 7 countries were in the expansion phase.
? IMCI discussions had started in at least another 13 countries.

In the Region, the Philippines and Viet Nam are in the early implementation phase of IMCI, while China, Myanmar and Indonesia are in the introduction phase.

The IMCI has provided a new impetus for efforts to promote child health and development. Agencies and institutions committed to improve child health have provided support for IMCI at country, regional and global levels. Significant research is being conducted to document the scientific evidence on the efficacy and effectiveness of IMCI and to contribute to IMCI operational guidelines and materials development.

**IMCI in Cambodia**

After an initial briefing on the IMCI strategy organized by the WHO for the MOH in February 1998, the Director of the Communicable Disease Control (CDC) Department was appointed as IMCI focal person. Preliminary discussions between the MOH, WHO, UNICEF and RACHA/USAID resulted in an IMCI Concept Paper outlining the introduction process of IMCI in Cambodia.

In April 1998, the principles of the IMCI strategy were formally adopted by the MOH and an IMCI Working Group was appointed under the chair of the CDC Department. The main scope of the IMCI Working Group - which comprised representatives from the Department of Human Resources (HRD), the Essential Drugs Bureau, National Programmes (COD/ARI, Nutrition, DHF/malaria) and partner agencies (WHO, UNICEF, RACHA/USAID, MEOICAM) was to plan and oversee the introduction of IMCI in Cambodia.

With assistance from WHO, RACHA and UNICEF, an IMCI orientation Workshop was conducted 23-24 June 1998 with 100 participants from the MOH, other ministries, IOs and NGOs. The proceedings and discussion outcomes were reviewed by the IMCI Working Group and focus group meetings organized in August and September to specifically discuss the following key topics:

? Adaptation of generic IMCI clinical guidelines

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Based on the outcome of focus group discussions, the National IMCI Planning Workshop was organized with WHO, UNICEF and RACHA technical and financial support on 26-29 October 1998. Working groups - identified during the focus group meetings - prepared draft workplans and identified activity areas requiring external collaboration or additional technical and financial support. The composition of sub-working groups, the management structure of the IMCI process and operational strategies were also discussed.

This National Plan of Action for the Early Implementation of IMCI in Cambodia builds on the work done and the discussions held during the IMCI Planning Workshop.

3. RATIONALE FOR INTRODUCING IMCI IN CAMBODIA

The need and the rationale for an integrated approach to prevent and treat major childhood illnesses - both in health facilities and at home - constitute the basis of the IMCI strategy.

Within the specific Cambodian context, the Ministry of Health has adopted the IMCI strategy based on the following analysis of the situation:

The IMCI addresses major health problems in Cambodia and covers most presenting complaints of sick children

- 78% of outpatient consultations for children under-five in Cambodia are associated with one or more of the IMCI target diseases.

- Acute respiratory infections (ARI) are by far the most common reason for hospital and outpatient consultations, accounting for almost 50 percent of all out-patient consultations for children under the age of five.

- Children under five years of age living in an urban area will suffer between 5 and 7 episodes of respiratory infection per year.

- 40 percent of infants aged 6-11 months had diarrhoea during the two weeks previous to the National Health Survey in 1998. 40 percent of the cases were of the dysentery type.

The IMCI strategy is likely to have a major impact on child morbidity and mortality

- The 1993 World Bank World Development Report, "Investing in Health", estimated the IMCI to have the potential to reduce child deaths by 50-70 percent in high-mortality communities - if high health utilization rates are achieved ("Investing in Health, page 114).
The majority of child deaths occur in the home, not in a health facility. The IMCI improves child health practices in the households, including preventative measures, early care seeking and compliance to prescribed treatment.

The IMCI strategy will improve quality of care of sick children in health centres:

- The IMCI responds to the needs for improved child health care in health centres as defined by the MOH in the Minimum Package of Activities (MPA).
- The IMCI has been demonstrated to improve case management skills of health workers (Validation of Outpatient IMCI Guidelines, CRD January 1998).
- IMCI training and follow-up is based on practical training (see chapter 10).
- IMCI training materials aim at improving interpersonal communication and counseling skills of health workers. Information on the child's disease, on home treatment and when to return have been shown to improve in health facilities offering IMCI services.

The IMCI strategy fills a serious gap by strengthening nutritional counseling and interventions for children and their mothers, including breastfeeding an complementary feeding.

- The problem of malnutrition is worse than earlier thought. A national survey in 1996 showed very high rates of malnutrition in the 6 to 59 months age group, with 53 percent moderate to severe underweight (>2SD - weight for 1se), 59, percent stunted (>2SD - height for age) and 3 percent wasted (>2SD - weight for height). Even more alarming are the rates of severe malnutrition (>3SD) with severe underweight at 18 percent, severe stunting at 34 percent and severe wasting a 3 percent. In addition to household food insecurity which is estimated-to- be a major causative factor in one third of malnutrition cases (using Body Mass Index (BMI) of below 18.5 in women as an indicator), the other main causes of child malnutrition are believed to be inadequate child care and poor complementary feeding practices, as indicated by rates of growth faltering being greatest in children between 6-18 months.
- IMCI has a strong nutrition counseling component (promotion and counseling on breastfeeding, complementary child feeding and appropriate nutritional management of sick infants and children) and micronutrient component.
- The IMCI presents a very good opportunity for implementation of the health facility-based and community-based components in the National Plan of Action for Nutrition.

The IMCI strategy fits well into health sector reforms and reorganization of district health services.

- IMCI services will strengthen the quality of child health services and will increase public confidence in public health facilities (improved health services reported by 90% of mothers in Peru, 1997).
- The IMCI optimizes the use of financial and human resources by promoting integrated delivery of child health services and integrated planning, training and supervision.
- The IMCI assigns the main responsibility for activity planning and monitoring to the district level.

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9 National Plan of Action for Nutrition, RGC January 1997: Priority 4: Prevention and Treatment (A Infectious Diseases; priority 5: Better Infant and Young Child Feeding

DRAFT NATIONAL PLAN FOR THE EARLY IMPLEMENTATION OF IMCI - 02/25/99
The IMCI strengthens referral pathways between the community, the health centres and the referral hospitals by clearly identifying which patients should be referred and how they should be treated prior to referral.

After an initial phase with increased investment (including training), the IMCI strategy is cost-effective and is ranked by the World Bank among the ten most cost-effective interventions in low- and middle-income countries.

**The IMCI provides a cross-sectoral framework to review national child survival and development strategies.**

- The IMCI promotes collaboration and cooperation between MOH programs, other ministries (MRD, MOE, MOWA...) and NGOs / IOs.
- The IMCI process offers the opportunity to capitalize on local experiences such as existing community-based programmes.
- The IMCI allows the review of IEC strategies for child survival, identification of the most effective channels for communication and standardization of messages to reinforce communication strategies for behavioral change.

**The IMCI will be a major operational strategy for the implementation of Primary Health Care policy and strategies.**

- The IMCI promotes prevention as well as cure - including immunization, improved infant and child nutrition and environmental sanitation.
- Operational guidelines will focus on strengthening linkages between health services and communities, defining roles and responsibilities of health workers, extension workers and other partners.
- Community-based IMCI activities (messages and services) will be based on key PHC elements and will include child and maternal health interventions.
- The IMCI improves equity in child health care by standardizing the consultation process in health centres.

**4. PRINCIPLES FOR IMPLEMENTATION OF IMCI**

**Main challenges for the IMCI**

Major challenges faced by the IMCI process in Cambodia include coordination, information sharing, human resource development, creating appropriate conditions for training and overcoming financial constraints. These challenges are being addressed jointly by the Ministry of Health and a broad group of partners (see chapters 9 and 12).

Being based on the concept of partnership; IMCI necessitates proper coordination and information sharing. It is crucial that all relevant MOH departments, national programmes, training institutions, health facilities, provincial and district level administrators, other ministries and international, bilateral and non-governmental organizations collaborate to plan, implement and evaluate IMCI activities in Cambodia. To facilitate collaboration and participation, an information centre will be run by IMCI Secretariat as outlined in chapter 9. The secretariat will
be responsible for general coordination and public information sharing both using the existing structures within the health system and through the media:

The development of human and other essential resources for IMCI activities, especially for clinical health worker training, requires significant investment. All IMCI tools must be adapted to the Cambodian context before production and use (see chapter 12). Resource persons needed to conduct IMCI training activities include course directors, clinical Instructors and facilitators. In order to ensure quality, they should be selected according to criteria specified in chapter 11 (see page ?) and all of them must first go through the clinical IMCI course and some additional training. A core group of about 20 people has to be trained as resource persons, in addition to the three IMCI facilitators already available in Cambodia, and at least one training site identified and developed. The training site must have a sufficient caseload of outpatients and inpatients, adequate training premises, an acceptable quality of care and staff interested and able to conduct a number of courses. In time, the supervisors of the continuing education system should complete the clinical IMCI course.

Securing funds to cover adaptation and training costs during the Early Implementation Phase of IMCI remains a critical challenge, together with creating a sustainable financing system at district level. Since valuable financial support from USAID through RACHA has decreased considerably, other funding sources need to be urgently identified for 1999. In the meanwhile, WHO will shoulder part of the adaptation and training costs and UNICEF the expenses of community-based IMCI activities.

Key implementation principles

? Development and implementation of IMCI interventions will be done in coordination with other relevant processes (compatibility with health sector reforms, adherence to national policies, collaboration with national programs and other ministries).

? IMCI activities will build upon existing local experiences. To achieve this close collaboration with several governmental ministries and non-governmental organizations must be achieved.

? IMCI interventions need to reach and converge at household and community level to achieve a substantial improvement in child survival, growth and development. An intersectoral approach and identification of effective channels for providing messages and services need to be identified.

? Linkages between health services and communities need to be strengthened - including establishing mechanisms for real community participation in health centres.

? Similar to health sector reforms and to implementation of primary health care policies, the IMCI strategy is a process that seeks to improve access, equity, quality, efficiency and sustainability.

Linkages to existing processes and structures

? The following table outlines the linkages between the IMCI, national programs and current reforms and work processes in the Ministry of Health. Coordination, collaboration and information-sharing among partners is essential to avoid duplication of work.
<table>
<thead>
<tr>
<th>Operational and technical areas</th>
<th>What IMCI can offer</th>
<th>What IMCI needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health worker training</strong></td>
<td>Problem-based integrated training package addressing main causes of child morbidity and mortality</td>
<td>Existing MOH policies and protocols reviewed and Compatible with IMCI protocols</td>
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<tr>
<td></td>
<td>Emphasis on practical training</td>
<td>IMCI protocol to replace MPA Module 3 in areas where IMCI is implemented</td>
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<tr>
<td><strong>Supervision of health centres</strong></td>
<td>Standardized and integrated assessment of management of sick children in health centres</td>
<td>Training sites with adequate patient load</td>
</tr>
<tr>
<td><strong>Essential Drugs</strong></td>
<td>Improved patient compliance and more rationale use of drugs (including reduced use of antibiotics)</td>
<td>Drug use policies compatible with IMCI</td>
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<td></td>
<td>Clear policy on drugs for childhood illness</td>
<td>Availability of essential drugs for IMCI</td>
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<tr>
<td><strong>Referral pathways and services</strong></td>
<td>Promotion of adequate referral with clear guidelines for referral and pre-referral treatment of very sick, children</td>
<td>Increased quality of care in referral hospitals</td>
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<td></td>
<td></td>
<td>MOH guidelines for referral services</td>
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<tr>
<td><strong>Health information system (HIS)</strong></td>
<td>Improved classification and diagnosis of childhood illness</td>
<td>Adaptation of HIS diagnosis and reporting system with IMCI classification of childhood illness</td>
</tr>
<tr>
<td><strong>Primary Health Care</strong></td>
<td>Operational framework for implementation of PHC policies in IMCI areas</td>
<td>IMCI acknowledged as an operational PHC strategy</td>
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DRAFT NATIONAL PLAN FOR THE EARLY IMPLEMENTATION OF IMCI - 02/25/99
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<tr>
<td>CDOIARI</td>
<td>? More effective case management</td>
<td>? CDD/ARI case management policies compatible with IMCI</td>
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<td></td>
<td>? Greater emphasis on nutritional aspects of diarrhoea case management</td>
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<tr>
<td>Malaria</td>
<td>? improved case management for children</td>
<td>? Policy on anti-malarial drugs management for children compatible with IMCI</td>
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<td></td>
<td>? Promotion of bednets</td>
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<td>EPI</td>
<td>? Case management of measles</td>
<td>? Vaccine availability</td>
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<td>? Reduction of missed opportunities</td>
<td>? Vaccination policies compatible with IMCI</td>
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<td></td>
<td>? Encouragement of routine vaccination</td>
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<tr>
<td></td>
<td>? Counseling on breastfeeding and complementary feeding</td>
<td>? Micronutrient, breastfeeding and complementary feeding policies compatible with IMCI</td>
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<td></td>
<td>? Treatment of malnourished children</td>
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<td>? Vitamin A and iron supplementation</td>
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<td>? Treatment of helminthes</td>
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<tr>
<td>Maternal and perinatal health</td>
<td>? Breastfeeding counseling</td>
<td>? Guidelines for illness in first week of life compatible with IMCI</td>
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<td>? Case management for sick young infants</td>
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<td></td>
<td>? Link between maternal health and child health services</td>
<td>? Clear guidance on available maternal health services</td>
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<td>? Opportunity to inquire about the mother's health and provide services</td>
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5. Overview of the Early Implementation Phase of IMCI

During the Early Implementation Phase, the Ministry of Health (MoH) and its partners will gain experience with implementing IMCI at central level and 2-3 Operational Districts (ODs) in Cambodia. As shown in figure 1, some steps of this process are parallel. They include planning, adapting IMCI tools for use in Cambodia, capacity building at central and district levels, training with follow-up, upgrading the health system, improving family and community practices, and reviewing activities. After taking these steps, those involved will know how to link IMCI with the health sector reform (HSR) and the overall planning system, how to build district capacity for implementing the strategy, and how much it all costs. The Early Implementation Phase also includes carefully monitoring and documenting activities to solve problems, to prepare for a review after 1-2 years of implementation, and to use these experience for strengthening future plans.

Target ODs for early implementation will be selected as described in chapter 9. In these pilot ODs, IMCI will replace disease specific ARI/CDD activities. Yet, the National ARI/CDD/Cholera Programme will continue to strengthen these activities in the rest of Cambodia.

National Plan

At first, some background information has been gathered and, based on this, a National Plan for the Early Implementation Phase of IMCI developed. Important information needed for the plan includes relevant data on the epidemiological situation, the health system, the training of service providers, the activities of national programmes, existing policies and clinical guidelines, and family and community practices in Cambodia. Using this information, a national workshop has been conducted to develop sub-plans (improving health worker skills, the health system, and family and community practices, monitoring, selection of pilot ODs and budget) which have been combined and adjusted to compile MCI plan (this document).

Adaptation

According to the plan, five sub-groups will carry out specific tasks concurrently during the Early Implementation Phase, two concentrating on adaptation work and three on sustainable implementation (see chapter 8). Before district level IMCI training can start, the adaptation sub-groups have to complete their work. After collecting relevant information, they will identify essential, recommended and possible adaptations, draft country-specific IMCI tools, reach consensus on the content in collaboration with all other sub-groups, translate, test and revise the training materials, and print them in quantity. Moreover, they will list drugs needed for the implementation of IMCI. One of these sub-groups will adapt the clinical IMCI guidelines. The other one will be responsible for adapting feeding recommendations, identifying feasible local terms, and developing a caretaker counseling card for use in Cambodia. Both of them will participate, together with implementation sub-groups, in adapting other training tools (modules, guides, forms and videos), and in ensuring the consistency of messages. Altogether, the adaptation and production of IMCI training materials is likely to take 6 to 18 months.

Improving health worker skills

While two sub-groups adapt IMCI tools, one of the remaining three will develop human resources and carry out other preparations for health worker training and follow-up. It will build training capacity both at central and district levels. As a parallel activity, it will develop a long-term national strategy for training in child health to define the roles of IMCI and other relevant
interventions such as those based on the Minimum Package of Activities (M=PA) approach. In line with the strategy, the sub-group will agree on the course format and optimal teaching methods, and prepare selection criteria as well as job descriptions for trainers and trainees. Furthermore, it will identify participants and resource persons as needed, and upgrade at least one training site for IMCI courses.

Improving the health system

One of the three implementation sub-groups will aim at improving health system support for the trainees. Such support includes efficient district level planning and management, enough IMCI drugs and equipment, well-organized work at first-level health facilities, proper referral pathways (caretaker and health worker behavior, transportation and referral hospital quality), appropriate supervision linked with follow-up, and a sensible system for monitoring (including the Health Information System). These will be promoted within the health sector reform context, not separately. Therefore, close collaboration with the Health Sector Reform Group (HSRG) of MoH will continue.

Improving family and community practices

At the same time, the fifth sub-group will work for improving child health related family and community practices. It will support community participation ensuring the compatibility of health education messages with IMCI. At first, it will identify key practices and the most successful experiences in promoting child health through families and communities. Based on these, the sub-group will design specific improved community-based interventions such as training for traditional birth attendants, monks and other influential partners in targeted communities. Finally, it will implement, monitor and evaluate these interventions. During this process, it will collaborate with IMCI partners in pilot areas and with the other two implementation sub-groups to link the communities and the district level health system together.

Building national capacity

Once the sub-groups have started their work, the next step is to build national capacity for the implementation of IMCI through proper training. The sub-group responsible for improving health worker skills will take the lead in this human resource development process. To obtain enough facilitators, clinical instructors and course directors who can provide IMCI training for first-level health workers at district level, a sequence of courses is needed (i.e. first IMCI clinical courses followed by training in facilitation and follow-up skills, see chapters 10 and 12).

District plans

As a parallel activity with building national capacity, pilot districts will develop plans for the Early Implementation Phase of IMCI. District level orientation will be arranged before such planning. The components of the district level plans will focus on training, health system support, community-based interventions, monitoring, supervision and budget. To prepare for IMCI courses and follow-up, district level resource persons, training coordinators and implementation teams will be identified.

Implementation at district level

Clear plans will guide the selected member of the OD health team who will lead local implementation as district focal person for IMCI activities. After adequate training, facilitators from pilot areas and other resource persons will conduct the planned clinical IMCI courses at district level. As the next step, the facilitators will go through a follow-up training course. Shortly thereafter, they will conduct follow-up visits as district team members. The teams will monitor and supervise health workers trained in IMCI, support them in problem solving, and document
activities at district level for reporting. Selected district staff will also implement community-based interventions as planned.

Review

After 1-2 years of implementation, when at least two rounds of follow-up visits have been conducted, IMCI will be reviewed in Cambodia. The review will end the Early Implementation Phase of IMCI. The implementation sub-groups and the district focal points will organize and analyze data to prepare a summary report on the achievements of IMCI, major problems encountered, their reasons and proposed solutions. In the report, they will evaluate the prospects of IMCI in Cambodia and conclude if it is feasible for the country to enter the Expansion Phase.

Before eventual expansion, only in-service training will be available during the Early implementation Phase. It will allow a quick review of initial experiences, show how the clinical IMCI guidelines perform in Cambodia, and provide the means to train teachers from pre-service institutions. The, pre-service training in IMCI may be considered based on the results of the review.

Figure 1. Steps in the Early Implementation Phase of IMCI.

6. Improving health worker skills through IMCI

A key element of the Integrated Management of Childhood (IMCI) approach is a case management training course for first-level health workers. This practical course combines various materials and teaching methods. Before conducting IMCI courses, training capacity must be built and these materials and methods adapted for use in Cambodia.

objectives

? By using appropriate training tools and, methods, several objectives will hopefully be met after health workers have completed the clinical IMCI case management course. The tasks listed below reflect these objectives, i.e. knowledge and skills ideally acquired during the course.

? Assess, classify and treat sick children aged between one week and five years accurately following IMCI guidelines

? Administer pre-referral treatment correctly and refer seriously ill children

? Counsel caretakers about home care

? Check children's immunization status routinely and give immunization if needed

? Carry out feeding assessment of children less than two years old or very low weight-for-age

? Provide caretakers with appropriate nutrition and breast-feeding counseling.

Target audience

The clinical IMCI training course has been developed for literate health workers based at first-level facilities (health centers and outpatient departments). The target groups will be doctors,
medical assistants, nurses, health assistants and other paramedical health worker who
deliver care for sick children at selected hospitals and health centers.

**Training materials**

Tools used during IMCI courses include treatment charts, training modules, guides for resource
persons, videos and some other teaching aids. Wall charts describe the case management
guidelines used in the training course. The same charts are also available in booklet form.
Moreover, the course uses seven training modules: Introduction, Assess and classify the sick
child age 2 months up to 5 years, Identify treatment, Treat the child, Counsel the mother,
Management of the sick young infant, and Follow-up. Instructions for training courses are
provided in the Course director's guide and in three facilitators' guides: Facilitator's guide for
modules, Guide for outpatient clinical practice and Guide for the inpatient clinical instructor.

In addition to the above materials, some other training tools are available to support clinical
practice by course participants in outpatient and inpatient settings. The participants use
caretaker counseling cards; photo exercises booklets and IMCI case recording forms, and
watch two videos entitled "Assess and classify the sick child" and "Assess and classify the sick
young infant".

**Adaptation of the course content**

For each country, the generic IMCI guidelines and training materials must be adapted to take
into account the local epidemiology of target diseases, the social and cultural context, and
national policies and guidelines. In other words, the treatment chart and all course materials
mentioned above will be modified, as needed, for use in Cambodia. This process will probably
take 10-18 months. The materials have to be developed through a collaborative process
involving relevant IMCI subgroups (see chapter 13), and then translated into Khmer. Some
steps of the adaptation process are listed below.

? Agree on timeline with relevant MoH units and partners

? Review data on major contributors to childhood mortality and morbidity, and add illnesses
important in Cambodia (such as dengue fever) on top of the five conditions covered by the
generic IMCI guidelines

? Identify adaptations to be considered

? Gather essential new information through studies, as needed

? Build consensus on national IMCI guidelines

? Prepare a document summarizing the technical basis of the national IMCI guidelines

**Training methods**

The training methods used during IMCI courses emphasize both theory and clinical practice.
Under the guidance of clinical instructors and facilitators, each participant attends 10 clinical
sessions.

Other teaching methods include written exercises, individual feedback, group discussions,
drills, presentations, short answer exercises and role-plays. Photographs and videos are use to
practice the accurate identification of clinical signs, including uncommon ones which indicate a
need for urgent referral.

DRAFT NATIONAL PLAN FOR THE EARLY IMPLEMENTATION OF IMCI – 02/25/99

Course director, clinical inpatient instructor and facilitators
Resource persons needed to conduct a clinical IMCI course include a director, an inpatient clinical instructor and several facilitators. The director coordinates the course while the clinical Instructor selects cases appropriate for practical sessions from an inpatient ward, assigns these to the participants and discusses their assessment and classification. This person must have the competence and confidence to carry out these tasks and to ensure that as many abnormal clinical signs as possible are correctly identified.

Course facilitators are selected from existing health facilities, training centers, and ARI and Diarrhoea Training Units. They must have a current clinical caseload, master standard IMCI case management and relevant teaching methods, be able to speak Khmer, and remain available for future training courses. Preferably, they should have previous training experience. Before they qualify to act as facilitators, they have to go through the clinical IMCI course and training in teaching methods. (See also chapters ?? and ??)

Training site

The first IMCI training courses will take place at the National Pediatric Hospital. In time, such training may begin at other sites with sufficient caseloads, access to outpatient and inpatient departments, acceptable quality of care and adequate human resources. It is essential that the director and staff of these training sites are interested and able to conduct a number of courses. Monitoring and documenting the quality of training courses

Quality criteria for IMCI training in Cambodia have been set, as follows:

- At least one facilitator for four participants
- Course duration at least 80 hours (estimated duration 15 days)
- Proportion of time in clinical sessions: 30% of total hours
- Average number of cases seen per participant: at least 20
- Number of course participants not more than 20
- All training modules completed at the end of the course
- Each participant receives his/her own copy of the chart booklet
- For the training of first-level health workers: on follow-up visit conducted within 4-6 week after training

Based on these criteria, the course director assesses the results of the clinical training and documents them in a summary report to the subgroup responsible for improving health worker skills through IMCI.

Follow-up

Follow-up after the clinical IMCI course is a crucial part of the training process and an important bridge to supervision. In Cambodia, one follow up visit will be conducted four to six weeks after training. These visits are essential because health workers face many challenges after they
have participated in the clinical course and started applying IMCI case management skills at their facilities.

The list below summarizes the objectives of the follow-up visits.

- To support the transfer of IMCI skills to clinical work in facilities
- To identify problems faced by health workers in managing cases; and solve these
- To gather information on health worker performance, and the conditions influencing monitoring and improving the implementation of IMCI

After appropriate tools have been developed, the following core activities should be carried out during all follow-up visits:

- Observe case management and give feedback and skill reinforcement
- Review facility support
- Facilitate problem solving
- Gather and summarize information for monitoring
- Complete a summary report of the visit

Moreover, those responsible for follow-up may interview caretakers to determine health message comprehension and satisfaction with services, and/or review records or patient recording forms.

It is important to link follow-up with routine supervision. Thus, IMCI trainers and routine district supervisors will conduct follow-up visits together. They should be district-based, trained in IMCI case management, facilitation techniques and follow-up, and available to conduct visits to facilities with health workers who have gone through the clinical course. After each round of follow-up visits, they will submit a summary report through the official channels of the health system for distribution to all relevant MoH departments, national programmes, health facilities (National Pediatric Hospital and any others implementing IMCI), training institutions and technical partners.

**Timing of central and district level in-service training activities**

Planned IMCI in-service training activities will include courses both at central and district level. To strengthen the driving force of IMCI process, it is important to conduct first a (model) demonstration course for central-level key people such as Working Group members, influential pediatricians, managers from relevant programmes and future facilitators. Next, a national clinical IMCI course (training of trainers) followed by facilitator training has been scheduled for early 2000. It will provide an opportunity to train facilitators for district-level courses and to try out the adapted IMCI tools before they are finalized and produced in quantity. Tentatively, district level IMCI in-service training will start in Cambodia quickly after this course; during the first half of 2000 (see master timeline annex??).

**Pre-service training**

In-service IMCI courses will show how the clinical guidelines perform and will provide the means to train teachers from pre-service institutions. Therefore IMCI pre-service training could follow quite soon, probably in 2001 or 2002.
Training language

With a single exception, all IMCI training planned for Cambodia will happen in Khmer. Only the central-level demonstration course will be conducted in English.

Coordination of training

For optimal effectiveness, someone has to link IMCI training activities -both with each other and with any relevant coexisting processes (see chapter 6). It is the chairman of the "Improving health worker skills" sub-group (#3, please refer to chapter 9) who will coordinate not only central and district level IMCI courses but also follow-up visits, and will be responsible for training staff to conduct them. At central level, the said subgroup will collaborate with all other relevant processes such as training activities carried out by certain national programmes or based on the Minimum Package of Activities (MPA) concept or the Safe Motherhood Initiative (SMIIRH). Master trainers and continuing education coordinators will be involved at regional and provincial levels. After going through necessary IMCI courses (clinical, facilitation and follow-up), they can take part in coordinating and conducting IMCI training activities, and in related monitoring, record keeping and reporting.

Sources of financial and technical support

Most financial and technical support for IMCI training activities in Cambodia will be provided by the World Health Organization and World Vision International. These organizations will have their representatives in the subgroup responsible for improving health worker skills through IMCI. Reproductive and Child Health Alliance (RACHANSAID) will be the third source of technical support for IMCI training.

7. Improving the health system

8. Improving family and community practices

9. MANAGEMENT OF IMCI

An efficient management structure is clearly needed to coordinate the numerous activities that constitute the Integrated Management of Childhood Illness (IMCI) strategy in Cambodia. After IMCI Orientation Workshop in June 1998, several international, bilateral and non-governmental organizations and other partners have already expressed their willingness to support the Ministry of Health in planning, implementing, monitoring and evaluating these activities. Due to the large number of involved MOH departments, national programmes, provincial and district level administrators, health facilities, training institutions; and other ministries and partners, their
roles and responsibilities during the process must be defined in detail. The national IMCI management structure outlined below takes care of this task partially. It is a core framework upon which details have to be added by the members of the individual structural units. The Communicable Disease Control Department/MOH has the overall responsibility for coordination through the structure.

The main elements of the national IMCI management structure include a working group, secretariat and five subgroups (figure 1). The most important decisions, e.g. on using funds and approving key documents, are made by IMCI Working Group which convenes relatively rarely and is responsible for advocacy, as well.

Together with IMCI Secretariat, the subgroups implement the decisions of the Working Group and prepare necessary documents. The Secretariat gathers and shares information for the other elements of the structure, and collaborates with the media. Subgroups #1 (adaptation of clinical guidelines) and #2 (nutrition and caretaker counseling) have a time-limited common objective, i.e. to adapt the generic IMCI tools for use in the Cambodian context. The remaining subgroups, numbered #3 (improving the health system), #4 (improving health worker skills) and #5 (improving family and community practices) and named according to the three components of the strategy, are responsible for its implementation. First, they make preparations for implementation in pilot districts, and once adapted tools become available they carry out clinical training courses and other IMCI activities on a continuous basis. Thus, the Secretariat and the subgroups need to meet more often than the Working Group, probably several times per month.

Based on recommendations made during the national IMCI Planning Workshop in October 1998, terms of reference (TOR) are hereby adopted and members assigned for all above structural units, as indicated in annex I.

10. OBJECTIVES 1999-2000

The overall goal of the IMCI strategy is to improve survival and contribute to healthy growth and development of Cambodian children by reducing morbidity and mortality associated with the major causes of childhood illness.
Specific objectives by the end of the year 2000 are:

? To adapt and field-test the generic clinical IMCI guidelines and training tools for implementation in Cambodia; including country-appropriate treatment protocols, feeding and fluid recommendations and caretaker counseling guidelines for health workers.

? To adapt IMCI operational guidelines with MOH : operational guidelines for district health services.

? To develop IMCI training plans - including identification and development of potential IMCI training sites.

? To develop and field-test health education strategies and materials addressing key health behaviours and practices.

? To implement all three IMCI components in two pilot districts.

? To evaluate the effectiveness of IMCI pilot activities.

? To produce a plan for the IMCI expansion phase 2001-2005,

? To identify funds for the expansion phase of the IMCI:


See annex I

12. Budget

13. Monitoring and evaluation

The monitoring and evaluation component is critical for the early implementation phase of IMCI and will provide the framework for reviewing activities, demonstrating achievements and planning for expansion. Without adequate and accurate information, conclusions cannot be drawn as to the usefulness and effectiveness of the IMCI approach - including which activities that worked well and problems that need to be addressed.

Measuring the impact of IMCI interventions on the health and nutrition of children (i.e. reductions in mortality and morbidity) is difficult for a pilot period of only two years and requires larger-scale surveys. Measuring changes in health system performance at district and health centre level and measuring changes in nutrition and health behaviours at family and community level may be the only practical way to monitor progress in IMCI pilot areas. By assuming that improved health system performance and improved health behaviours and practices of caretakers have an impact on infant and child morbidity and mortality, the effectiveness of IMCI interventions might be demonstrated.

Essential components to monitor include:
Data collection will be based on:

- facility-based records routinely collected through the health information system (HIS)
- Special surveys - such as household base-line and follow-up surveys.

An IMCI monitoring framework will be developed - with a definition of methods of collection - will use the same indicators for measuring health centre and district performance as those selected by the MOH for monitoring health sector reforms. Monitoring tools and guidelines will as a general rule be those already introduced by the MOH ("Tableau de Bord", integrated supervision...). In case existing tools and systems do not meet the monitoring requirements of the IMCI, improvements will be proposed and discussed.

The Cambodia IMCI will contribute to global IMCI monitoring by collecting the necessary information to report achievement of set milestones for IMCI implementation-, as defined by WHO.
IMCI Advisory Committee

Rationale for IMCI Advisory/Steering Committee

- Authority to coordinate National Programmes and other relevant MoH units (prevents problems in case of disagreement)
- Ability to provide high level policy support
- Endorsement to plans, key decisions and activities of IMCI Working Group either through written documents or meetings
- Relatively infrequent meetings chaired by a senior MoH official (Secretary of State or Under-Secretary of State) who carries the overall responsibility for IMCI or, in the absence of this person, by the chairman of the Working Group

Terms of reference

- To review and validate the progress of IMCI at least once in six months
- To facilitate high level and policy decisions as needed

Members

- Chairman: Dr Mam Bun Heng, Secretary of State
- Vice-Chairman: Dr Sok Touch, Deputy-director of CDC Department, chairman of IMCI Working Group
- Other members:
  - Dr Lo Veasna Kirby, Vice-Director of PHI Department, Project Manager of the Health Sector Reform Group (HSRG)
  - Dr Kum Kanal, Director of National MCH Center
  - Dr Chhour Y Meng, Director of the National Pediatric Hospital
IMCI Working Group

Terms of reference

- To coordinate the work of National Programmes, sub-groups, other MoH units and partners involved in the adaptation and implementation of IMCI
- To carry overall responsibility for the adaptation of IMCI guidelines
- To provide technical support and advise for the IMCI focal person
- To select pilot districts for the Early Implementation Phase of IMCI
- To plan, implement and monitor IMCI activities at central, provincial and district levels
- To prepare budgets and reports for approval by the Minister of Health
- To submit quarterly progress reports to CoCom
- To finalize the annual IMCI report drafted by the secretariat
- To propose any changes in IMCI management structure for the Minister of Health
- To select 3-G members of the Working Group to act as a secretariat who will maintain an IMCI information center including a library, sufficient stocks of relevant documents and properly organized computer files
- Print and store adapted NCI materials and coordinate their distribution
- Keep the subgroups continuously informed about recent IMCI related global, regional and national developments
- Collaborate with the media through the Information Office of MoH
- Estimate costs based on input from subgroups and to identify and coordinate funding needed for the implementation of IMCI
- Propose pilot districts for the Early Implementation Phase of IMCI after consultation with the subgroup assigned to improve the health system
- Draft an annual IMCI report for the Minister of Health and quarterly progress reports for cocoa

Members

Chairman: Dr Sok Touch, CDC Department
I MCI Subgroup #1: Adaptation of clinical guidelines

Terms of reference

? To review child health related research findings, national policies and treatment guidelines
? To obtain additional information through special studies as needed for adapting the clinical IMCI guidelines
? To adapt clinical IMCI guidelines and training tools for implementation in Cambodia
  - to recommend first- and second-line antimicrobial treatment for very severe disease, pneumonia, acute ear infection, dysentery, cholera, local bacterial infections in young infants and malaria
  - to agree on pre-referral treatment of very severe disease in collaboration with the subgroups responsible for improving the health system and the skills of relevant staff (#3 and 4)
  - to define optimal home treatment for mild cases of ARI, diarrhoeal disease, malaria, measles and dengue fever
  - to recommend, in collaboration with the nutrition and care taker counseling subgroup (#2), vitamin A supplementation for sick children
- to field test the adapted IMCI guidelines including recommendations on feeding and fluid therapy in collaboration with the subgroup responsible for nutrition and caretaker counseling (#2)

- To develop IMCI drug list in collaboration, with the subgroup responsible for improving the health system (#3)

- To develop counseling guidelines for health workers on the home care of diseases covered by IMCI in collaboration with the other relevant subgroups (#1, 2 and 5)

? To keep the IMCI Secretariat informed about the progress in the adaptation of the clinical guidelines

? To prepare a report summarizing the technical basis of cynical adaptations and grouping them as essential, recommended or possible

? To finalize the adapted clinical guidelines after a consensus meeting with other IMCI subgroups and the advisory council

? To propose improvements, as needed, for the essential drug list, national policies and treatment guidelines accordingly

? To prepare treatment charts, training modules and a Course Director's guide based on the adapted IMCI guidelines and to translate these into Khmer in collaboration with the subgroups responsible for nutrition and care taker counseling (#Z) and for improving health worker skills (#4)

? To produce in collaboration with the nutrition and care taker counseling subgroup (#2) the adapted IMCI tools both in Khmer and English

Members

Core team

? National MCH Center. ARl/CDD/Cholera Programme
? National Pediatric Hospital (MPH) Preventive Medicine Department (PM/MoH)
? National Malaria Center (CNM)
? Communicable Disease Control Department (CDC/MoH)
? Kreditanstalt fur Wiederaufbau (KFW)
? World Health Organization (WHO)
? Reproductive and Child Health Alliance (RACHA)

Others

? Director of CDC Department
? NPH
? Essential Drugs Programme (EDP)
? Pasteur Institute
? Angkor Hospital for Children
? Representatives of pilot districts (e.g. Kampong Chhnang)
? Kuntha Bopha Hospital
? WHO
IMCI Subgroup #2: Nutrition and caretaker counseling

Terms of reference

? To review research findings, health education materials, national policies and guidelines related to child nutrition and studies on the knowledge, attitudes and practices of caretakers

? To obtain additional information through special studies as needed for adapting IMCI feeding recommendations and developing health education messages and materials

? To adapt clinical IMGI guidelines and training tools for implementation in Cambodia
  - to develop feeding recommendations for healthy and sick children less than five years old
  - to prepare recommendations on per oral and intravenous fluid therapy for sick children less than five years old in collaboration with the subgroup responsible for adapting the clinical IMCI guidelines (#1)
  - to field test the above feeding and fluid recommendations and to finalize them in collaboration with the subgroup responsible for adapting the clinical IMCI guidelines (#1)
  - to recommend vitamin A supplementation for sick children in collaboration with the subgroup responsible for adapting clinical IMCI guidelines (#1)
  - to develop counseling guidelines for health workers on the home care of diseases covered by IMCI in collaboration with the relevant subgroups (#1, 4 and 5)

? To adapt and field test the counseling section of the IMCI chart for mothers’ own health

? To keep the IMCI Secretariat informed about the progress in adaptations that concern feeding and caretaker counseling

? To prepare a report summarizing the technical basis of adaptations that concern feeding and caretaker counseling, and grouping them as essential, recommended or possible

? To finalize the adapted IMCI guidelines after a consensus meeting with other subgroups and the advisory council

? To propose improvements, as needed, for relevant national policies and treatment guidelines accordingly

? To prepare treatment charts, training modules and a Course Director’s guide based on the adapted IMCI guidelines and to translate these into Khmer in collaboration with the relevant subgroups (#1 and 4)

? To develop and test written and pictorial health education messages and materials for counseling caretakers on feeding, oral rehydration and other aspects related to IMCI

? To produce the adapted IMCI tools in Khmer and English by cooperating with the subgroup responsible for clinical guidelines (#1)

Members
Core team

- National MCH Center: Nutrition Programme (3)
- National MCH Center. ARI/CDD/Cholera Programme
- Communicable Disease Control Department (CDC/MoH)
- National Center for Health Promotion (NCHP)
- Helen Keller International (HKI)
- CARL International Cambodia

Others

- National MCH Center. Nutrition Programme
- Preventive Medicine Department (PMIMoH)
- National Institute of Public Health (NIPH)
- NCHP, AUSAID
- Kuntha Bopha Hospital
- CHED?
- United Nations Children's Fund (UNICEF)
- WHO
- HKI

**IMCI Subgroup #3: Improving the health system**

**Terms of reference**

- To collaborate continuously with the Health Sector Reform Group
- To keep the IMCI Secretariat informed about the progress in health system development
- To identify potential pilot districts for the Early Implementation Phase of IMCI.
- To support planning and supervision in pilot operational districts that will implement IMCI
- To identify funding for relevant Minimum Package of Activities training (e.g. pre-opening health center training)
- To seek advise from the Health Economic Task Force for improving health center financing
- To collaborate with the subgroup responsible for adapting the clinical IMCI guidelines (#1) in the development of IMCI drug list
- To recommend IMCI related improvements to the National Essential Drug List when it is revised
- To ensure the supply of IMCI drugs through the national delivery system and to identify resources for them as needed in close collaboration with the Essential Drugs Bureau and relevant district level officials
- To agree on the pre-referral treatment of very severe disease in collaboration with the subgroups responsible for adapting the clinical guidelines and improving health worker skills (# 1 and 4)
- To evaluate the referral system by reviewing past experiences and assessing knowledge, attitudes and practices in collaboration with the subgroup responsible for improving family and community practices (#$)
To provide guidance for health centers and hospitals for strengthening the referral system in collaboration with the subgroup responsible for improving family and community practices (#5)

To review the standardized supervisory checklist and to develop a complementary IMCI specific attachment if needed

To link supervision with IMCI follow-up visits, to monitor the performance of trainees, and to report results to relevant MoH units in collaboration with the subgroup responsible for improving health worker skills (#4)

To make a plan for taking IMCI into account when the Health Information System is revised

To monitor and evaluate progress through early short assessments at health center level

To select relevant items from HSR indicator framework for monitoring IMCI and to develop, if needed, a complementary tool for the same purpose

To establish systems for quality surveillance and self-improvement

Members

- Planning and Health Information Department (PHI/MoH) HSRG
- EDP/MoH
- PM/MoH
- Hospital Services Department (HS/MoH)
- CDC/MoH
- National ARI/CDD/Cholera Programme
- National Nutrition programme
- CNM
- EDP
- EPI
- Health Economic Task Force (HETF)
- WHO (2)
- UNICEF
- MEDICAM

IMCI Subgroup #4: Improving health worker skills

Terms of reference

- To review prevailing case management practices, human resources available and current training plans

- To develop short and long term IMCI training plans regarding both basic and continuing education (sequence of events, monitoring, evaluation etc.)

- to develop job descriptions for trainers and trainees

- to define criteria for selecting trainers and trainees

- to agree on course format and to select appropriate teaching methods
To participate in the adaptation of IMCI training tools taking into account the document entitled "Guidelines for Referral Hospitals"

- to agree on the pre-referral treatment of very severe disease in collaboration with the subgroups responsible for adapting the clinical guidelines and improving the health system (#1 and 3)
- to prepare treatment charts, training modules and a Course Director’s guide based on the adapted IMCI guidelines and to translate these into Khmere in collaboration with the adaptation subgroups (#1 and #2)
- to adapt generic IMCI tools for conducting follow-up visits
- to develop counseling guidelines for health workers on the home care of diseases covered by IMCI in collaboration with the relevant subgroups (#1, 2 and 5)
- To identify and develop IMCI training sites
- To build training capacity for national and district level IMCI courses including follow-up visits
- To facilitate the development of the human resource database and review the availability of "multi-skilled" health workers
- To link supervision with IMCI follow-up visits, to monitor the performance of trainees, and to report results to relevant MOH units in collaboration with the subgroup responsible for improving health worker skills (#4)
- To keep the IMCI Secretariat informed about the progress in improving health worker skills
- To define needs for other supportive training
- To consider involving the private sector in training activities

**Membership**

**Core team**

- NPH
- HRD
- ARI/CDD/Cholera Programme
- CNM
- CDC
- Technical School for Medical Care (TSMC)
- Medical Faculty
- WHO
- World Vision International (WVI)
- RACHA

**Others**

- HRD
- National Nutrition Programme
- CDC
IMCI Subgroup #5: Improving family and community practices

Terms of reference

- To review existing community-based operational experiences in PHC/child health, including collection and review of documents, field visits and preparation of recommendations for "best practices"

- To review available documentation concerning health knowledge, attitudes and practices in families and communities, identify information gaps and conduct formative research that will allow to define priority key behaviours and practices (in collaboration with Subgroup #2)

- To define the elements of a community IMCI package (messages and services), including linkages, roles and responsibilities of actors in the communities (in collaboration with Subgroup #2)

- To develop communication strategies targeting families and communities with a standard set of messages addressing the identified key health behaviours and practices, including identification of effective channels of communication (health centre, HC Feedback Committee, Village Development Committee, schools; pagodas, private sector. . .)

- To design messages and produce materials/tools for use in IMCI pilot areas (in collaboration with Subgroup #2, IMCI Secretariat and other partners)

- To collaborate with the PHC Policy Task Force in the development of a national primary health care policy

- To develop an implementation plan for pilot operational districts, including planning, training, communication and monitoring components

- To develop a plan for monitoring and evaluating the effectiveness of community-based IMCI activities

- To ensure that ministries and IOs/NGOs involved in Primary Health Care (PHC), child and maternal health activities at community-level are at a minimum informed about and, when possible/appropriate, involved in the process of developing and implementing IMCI activities

- To develop a communication and counseling module, Media Messages for Health Workers in collaboration with IMCI Secretariat

- To keep IMCI Secretariat informed about the progress in improving family and community practices

- To keep collaborating with the local authorities, such as village/community chiefs and district managers
Members

Core team

? CDC
? National Nutrition Programme
? National ARI/CDD/Cholera Programme
? Ministry of Rural Development (MRD)
? NCHP
? UNICEF: CASD and health (2)
? MEDICAM

Others

? PM
? Ministry of Women’s Affairs (MOWA)
? Ministry of Education (MOE)
? Representatives of pilot districts
? UNDP, CARERS: Central and Provincial Advisor (2)
? CARE International Cambodia
? Catholic Relief Service (CRS)
? Adventist Development and Relief Agency Cambodia (ADRA)
? Partners for Development (PFD)
? VWAI
? RACHA?
? WHO?
Annex IV Criteria for selection of pilot Operational District

For the Early Implementation Phase of IMCI, 2-3 operational districts (ODs) will be selected to gain experience with the strategy through a well-defined set of activities within a limited geographical area. Such experience is used to guide future planning and implementation. Therefore, the selected pilot ON should have high probability for success and replication of IMCI activities. The first IMCI training and monitoring activities will be conducted in these ODs. To gain broad enough experience, it may be important to select different types of districts, for example peri-urban and rural. Criteria to be considered while selecting IMCI pilot districts are summarized below.

- Ability at OD level to plan and manage IMCI activities (upgraded or planned lobe upgraded ODs):
- District Management Team (DMT) and Districts Health Technical Advisory Team (DHTAT) established (and functioning)
- Integrated supervisory system for health centers in place
- At least three MPA health centers with minimum case loads as defined by MoH
- A functional essential drugs (ED) management and supply system in place (enough EDs available at health centers)
- Sufficient and committed staff to do planning management (some have experience with management of drug availability and of training; or some have previous experience with these tasks for ARI/CDD, or there is good feasibility of involving supervisors in doing follow-up)
- Provincial commitment and support to IMCI
- Good physical access to central-level staff (for ease of travel for planning; assistance performing activities, monitoring)
- Availability of or access to a suitable training site with access to inpatients and outpatient facilities for clinical practice
- Ability to refer severely ill children from first level facilities for acceptable care
- Existing community-based-activities
- Support from international, bilateral and/or non-governmental organizations (eg. a Provincial Health Adviser available)
Annex V: List of Participants at the 1MCI Planning Workshops- October 1998

Ministry of Health

Buin Sreng            CDC
Chhorn Veasna         NMCHC
Chan VuthY            CDC
Chroeun Sokhan        DDF
Khan Chivnang         CDC
Chhin Lan             NMCHC
Chuong Sokhom         OD (K. Chhang)
Heng Bun Chhom        Director of PHD (Siemreap)
Dr Eng. Hout          
Hong Ratharmony       CDC
Ith Sakhoeneun        CDC
Im Chetra             CID Svay Por-(BB)
Khun Chan Pha         CDC
Khy Pahilly           Acting Director of NMCHC
Koam Kanal           
Dr Kuon Eng Mony      Preventive Medicine Dept.
Koy Bunthor          DDF
Keo Sony              NMCHC
Kov Bun In            ADBIMOH
Ly Khun Bunnaran      CDC
Kek Sambath           OD (Svay Rieng)
Moeung Data          International Relation Dept.
Dr Mom Phalkun        CDC
Dr Mam Bun Heng
Mel Yuong             DOH (BB)
Nuth Sinath           OD Director (Takeo)
Ngan Chantha          CNM/DHF
Dr Or Vandin          
Ou Kevann             ARI/CDD/Cholera Prog.
Ouk Poly              Nut. Programme Manager
Oum Sophallyn         CDC
Penh Chuong           CDC
Pok Chansophea        Preventive Medicine Dept,
Pheng Visoth          HRD
Dr Phum Sam Song      HRD
Sinath Ousophea       CDC
Seng Heng             CDC
Seng Khun             CDC
Dr Sokkana            
Sek Sokhean           CDC
Sav Sokun Mealiny     NMCHC
Sov Touch             CDC
Sok Kanha             HETF
Te tong Sin           Director (Takeo)
Thach Vanroeven       PH
Touch Data            NMCHC
Tuy Tanvathy          Chief of Health Promotion Office
Ung Thol              HRD

Health. Academic and Training Institutions

Ang Kim Long          NPH
Dr Chan Sorya        NIPH

DRAFT NATIONAL PLAN FOR THE EARLY IMPLEMENTATION OF IMCI – 02/25/99
Chan Sary  
Khantha Bopha Hospital  
Dr Kruy Sunlay  
Vice Director ( IPC)  
Kim Phearam  
Nurse Educator( TSMC )  
Lim Pich  
NCH?  
Ly Sim Cheng  
Faculty of Mixte  
Nou Som  
NPH  
Ourng Rin  
Chief of Ward ( NPH )  
Dr Po Samnang  
NCHP  
Sdoeung Chea  
NPH  
Tuy Tanrathy  
NCHP

Other related Ministries and Departments

Chea Samnang  
Director of DRHC Dept.  
Chhan Maly  
TV 3  
Khun Ngeth  
Deputy Director General of MRD  
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