SECOND WORKSHOP ON
INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI)

Manila, Philippines
25 – 29 August 2003

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REPORT
SECOND WORKSHOP ON
INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI)

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NOTE

The view expressed in this report are those of the participants in the Second Workshop on Integrated Management of Childhood Illness and do not necessarily reflect the policies of the World Health Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the Second Workshop on Integrated Management of Childhood Illness, which was held in Manila, Philippines from 25 to 29 August 2003.
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CONSULTANTS, RESOURCE PERSONS, OBSERVERS,
REPRESENTATIVES AND SECRETARIAT

ANNEX 2 - TIMETABLE
Since first introduced in 1995, Integrated Management of Childhood Illness (IMCI) has become a major strategy for child survival, healthy growth and development in an increasing number of countries in the Western Pacific Region. The first IMCI workshop held in Ha Noi, Viet Nam in October 1999 called for participating countries and partner agencies in the Region to advocate IMCI as the main strategy in child health and to put child health higher on the political and development agenda. Four years after the first regional workshop, 12 countries are implementing IMCI and expanding it in geographical coverage and scope of activities.

New approaches, directions and partnerships in child health have evolved as countries strive to improve their health indicators towards the attainment of the Development Goals of the Millennium Declaration (MDGs). A gathering of representatives of IMCI implementing countries and partner agencies in child health was therefore warranted to review the progress made to date, draw lessons from country experiences, share materials, tools and methods in new technical areas of child health, and to discuss strategies to scale up IMCI in the Region.

The second Regional Workshop on IMCI was held in Manila, Philippines from 25 to 29 August 2003. The objectives of the workshop were:

(1) to review progress in child health since the first regional IMCI workshop, and to share country experiences and lessons learned;

(2) to discuss the latest developments in child health, including materials, tools and methods in the major technical areas, particularly pre-service education;

(3) to review the Regional Framework for Community IMCI and discuss the way forward in improving family and community practices; and

(4) to identify ways to ensure the sustainability of IMCI within the context of child health and health system development, enhance partnerships and outline a plan for resource mobilization and scaling up of IMCI in order to maximize child health outcomes in the Region.

Attended by around 80 participants, the workshop examined current approaches to child health in the Region, and was impressed by the progress made by countries in advancing public health approaches in child health. At the same time, the workshop was very concerned about the 3000 under-five deaths that still occur in the Region every day, even though effective life-saving interventions are available. The workshop called for intensified action in child survival involving the governments and international health community alike in the joint efforts to save children’s lives.

In light of the forthcoming discussions on child health at the 54th Session of the Western Pacific Regional Committee, the workshop made the following conclusions as a way forward in child health in the Region:

(1) Impressive progress has been made in IMCI implementation in the Region. Twelve countries have embraced IMCI as the strategy to reduce childhood mortality and morbidity, and 11 countries have already passed the comprehensive adaptation process.
(2) Countries are now facing the challenge of scaling up IMCI to maximize coverage of the priority child health interventions covered by the IMCI strategy to promote child survival, growth and development. This requires change. The focus must shift from process to health outcomes that are directly linked to the reduction of child mortality and morbidity.

(3) There is a strong interest and general acceptance of all stakeholders to institutionalize IMCI by including it in the pre-service education of doctors, nurses and midwives.

(4) Teaching institutions provide a valuable setting for promotion, advocacy and visibility of child survival interventions, since a large proportion of newly qualified graduates find their first jobs at the primary health care level where they provide care to children and counsel caretakers.

(5) Key family and community practices are evidence-based and help promote growth and development, prevent disease, increase use of health services and reinforce messages for health care providers.

(6) WHO, the United Nations Children's Fund (UNICEF), nongovernmental organizations, community-based organizations and other partners assist governments and communities to put key family and community practices in place, albeit through different mechanisms and under different names. There is a need for national coordination for resource generation and maintenance of standards using indicators as well as enabling health policies that allow collaboration in community child health activities between all stakeholders.

(7) The four elements of the *Regional Framework for Community IMCI*, partnerships and linkages, community participation, health information and promotion, and means for improving key practices will be the key to improve community and family practices.

(8) The approach to mobilize resources for IMCI and other aspects of scaling up should be reviewed by countries and by the WHO Regional Office for the Western Pacific, taking into account the many useful suggestions made by the workshop participants.

(9) The workshop request that WHO and UNICEF make every effort to harmonize the promotion and implementation of IMCI and Integrated Early Childhood Development (IECD) strategies to avoid confusion and competition for funds and to enhance their true complementarity.

(10) The workshop requested that the forthcoming Western Pacific Regional Committee of WHO discuss ways of revitalizing and intensifying child survival activities in countries and areas where mortality remains high, in keeping with a commitment to the achievement of MDG 4 which calls for reducing the under-five mortality by two thirds based on the 1990 figures.

(11) Any new initiative on child survival, using IMCI and IECD as the main tools, should be well focused in content and well-targeted at the most vulnerable children, clearly state the expected outcomes and regularly monitor progress on a key set of indicators.
1. INTRODUCTION

1.1 Background

The Western Pacific Region has experienced significant overall improvements in child health during the past years. Yet, 3000 children under-five years old die every day in the Region, indicating that child mortality and morbidity continue to be major public health concerns in a number of countries. Preventable communicable diseases take a heavy toll on children, and poverty, unhealthy environments and low levels of access to and utilization of quality health services further contribute to the situation.

Since its introduction in 1995, Integrated Management of Childhood Illness (IMCI) has become a major strategy for child survival, healthy growth and development in an increasing number of countries in the Western Pacific Region. The first regional workshop was held in Ha Noi, Viet Nam in October 1999. The workshop called for participating countries and partner agencies in the Region to advocate IMCI as the main strategy in child health and to put child health higher on the political and development agenda. Four years after the first regional workshop on IMCI, 12 countries have responded to that call, expanding the IMCI strategy in geographical coverage and scope of activities. New approaches, directions and partnerships in child health and development have also evolved as countries strive to improve their health indicators towards the attainment of the Development Goals of the Millennium Declaration (MDGs).

In view of the recent development in child health in the Region and the remaining challenges ahead in taking effective strategies to scale, a gathering of representatives of IMCI implementing countries and partner agencies in child health was warranted to review the progress made to date, draw lessons from country experiences, share materials, tools and methods in new technical areas of child health, and to discuss strategies to scale up IMCI. The second Regional Workshop on IMCI was held in the premises of the WHO Western Pacific Regional Office, in Manila, Philippines from 25 to 29 August 2003.

1.2 Objectives

The objectives of the workshop were:

(1) to review progress in child health since the first regional IMCI workshop, and share country experiences and lessons learned;

(2) to discuss the latest developments in child health, including materials, tools and methods in major technical areas, particularly pre-service education;

(3) to review the Regional Framework for Community IMCI and discuss the way forward in improving family and community practices; and

(4) to identify ways to ensure the sustainability of IMCI within the context of child health and health system development, enhance partnerships and outline a plan for resource mobilization and scaling up of IMCI in order to maximize child health outcomes in the Region.

1.3 Participants and resource persons

This workshop brought together 77 attendees, including government officials from 12 countries, eight regional resource persons as consultants and temporary advisers, and 26
observers. The latter included representatives from the Asian Development Bank (ADB), bilateral development agencies such as Japan International Cooperation Agency (JICA) and the United States Agency for International Development (USAID), research institutes, professional associations for paediatricians, nurses and midwives, Australian Agency for International Development (AusAID)-funded Women's and Children's Health Project in Papua New Guinea, Ministry of Health officials from Indonesia and Japan, and a large number of nongovernmental organizations (NGOs) that are active in the field of child health in the Region.

Ten WHO staff from Headquarters, regional and country levels served as the secretariat to the workshop, and as usual, the workshop was conducted with close collaboration with the United Nation Children's Fund (UNICEF) whose officers represented both regional and country levels.

The detailed list of participants is attached as Annex I.

1.4 Opening remarks

Dr Shigeru Omi, Regional Director of the WHO Western Pacific, opened the meeting. In his opening remarks, Dr Omi noted the considerable increase in the number of countries implementing IMCI since the last meeting in 1999. He pointed out that each day about 3000 children under five years of age die from preventable diseases in the Region. He also reminded the participants that the causes of most of these deaths are known and that technically sound and effective interventions exist to prevent or treat the common conditions, yet they do not reach those children in greatest need. The necessity to scale up child health interventions covered by the IMCI strategy, and to target areas in greatest need was emphasized. He praised the good collaboration with UNICEF and other partners and called for using the potential of IMCI to contribute to the achievement of the MDGs. Dr Omi reminded the participants of the significant challenges related to the commitment towards the targets set, resources necessary to take essential interventions to scale, and sustainability of the efforts in child health.

Dr Stephen J. Atwood, Regional Adviser, Health and Nutrition, UNICEF East-Asia and Pacific Regional Office (EAPRO), addressed the meeting on behalf of Dr Mehr Khan, EAPRO Regional Director. He likewise stressed the importance of the MDGs, reaffirmed at the United Nations Summit that offer clear and challenging objectives for the immediate future. Dr Atwood emphasized the opportunity for both agencies to focus on common goals. He also highlighted the MDG number 4 urging to reduce the under-five mortality by two thirds based on the 1990 figures, and that countries and stakeholders should focus on this goal through IMCI. He also pointed out the importance of taking into account the linkages and interdependence of the different MDGs. Dr Atwood encouraged participants to review, in all honesty, the achievements that have been made and the constraints faced with the IMCI implementation. This review should be used to improve the implementation of the strategy.

Dr Myrna Cabotaje of the National Center for Disease Prevention and Control, Department of Health, Philippines, was appointed Chairperson, and Dr Timaima Tuiketei of the Ministry of Health, Fiji, was appointed Vice-Chairperson of the workshop. Five country representatives served as Rapporteurs. They were: Dr Gochoo Soyolgerel of the Ministry of Health, Mongolia; Dr David Mokela of Port Moresby General Hospital, Papua New Guinea; Dr Bounleua Oudavong of the Maternal and Child Health Centre, Ministry of Health, Lao People's Democratic Republic; Dr Sok Touch of the Ministry of Health, Cambodia; and Mr Len Tarivonda of the Ministry of Health, Vanuatu.
2. PROCEEDINGS

The proceedings of the workshop were divided into four technical sessions. The first session presented global and regional overviews of child health and reviewed progress in IMCI implementation in the 12 participating countries. The following sessions focused in particular on the technical areas of pre-service education and improving family and community practices, while in the last session participants discussed issues related to scaling up and sustainability of IMCI, concluding the session with a visionary way forward for child health in the Region.

The agenda of the Workshop is attached as Annex 2.

2.1 Session I: Progress in child health

The objective of the first session was to review progress in child health since the first regional IMCI workshop, and share country experiences and lessons learned. Papers were presented on the global and regional overview and this was followed by country presentations by the 12 IMCI implementing countries.

2.1.1 Global overview

A significant overall reduction in child mortality has been achieved over the last decades but there are inequalities in this progress between and within countries. There is a global commitment to the MDGs, particularly the health-related ones, that should foster efforts of countries and the international health community to promote child survival and child health. At the same time, there are also challenges to be faced in progressing towards the MDGs that are not linked to the health sector.

The recently published series of articles on child survival in the medical journal, *The Lancet*, and the considerable attention that they have stimulated have brought awareness to the issue of the fading attention in child health as well as the overall decline of funding levels. It was noted that it is also encouraging that the new Director General of WHO, Dr Jong-wook Lee has given renewed attention to child health and child survival.

Preliminary key findings of the Multi Country Evaluation of IMCI effectiveness, cost and impact, and the Analytical Review of IMCI implementation carried out recently reiterated that IMCI leads to improved quality of care for children and enhanced coverage of essential health interventions, provided that sufficient resources are available. More advocacy for child health and a closer look at implementation related issues such as human and financial resources, monitoring and evaluation are needed.

In the discussion that followed the presentation, the stewardship role of WHO as a technical agency was restated. It was also reiterated that there is a need for disaggregating national data on child health by geographic distribution and socio-economic determinants in order to target child health interventions at areas and groups in greatest need, calling for a focus on interventions as opposed to universality. The role of IMCI as a tool for achieving the MDGs in child health was pointed out as well as the need to keep it focused on the most prevalent conditions and to simplify the overall messages to policy-makers.

2.1.2 Regional overview

Similar to the situation globally, there has been a dramatic decline in the under-five mortality level in the Region yet the decline has been unequal among countries. Strong
commitment exists towards the MDGs and the 12 participating countries have embraced IMCI as a major strategy to improve their child health indicators. Currently, one country, Kiribati, is in the introduction phase of IMCI, while six of them (Fiji, Lao People's Democratic Republic, Malaysia, Papua New Guinea, Solomon Islands and Vanuatu) are in the early implementation phase. Five countries (Cambodia, China, Mongolia, Philippines and Viet Nam) have proceeded to the expansion phase.

Key achievements in countries with respect to IMCI implementation as well as improvements in quality of care after IMCI training and caretakers' satisfaction were presented. The dependence on sufficient facility support in order to achieve these improvements was recognized. It was noted that a total of about 14 000 health workers had been trained so far in the IMCI inservice courses in the Region. In order to broaden the coverage of IMCI skills, pre-service education is also being introduced in seven countries in medical, nursing and midwifery schools.

After the presentation, participants acknowledged that considerable achievements had been made. However, these achievements were not yet sufficient to expect a considerable impact on the reduction in child mortality rates in the Region, as would be required to reach MDG 4 by 2015. It was recognized that to continue business as usual was not an option. There was a consensus that the investments made in IMCI in the past were not sufficient to meet the needs. There was also a call to look more at child health outcomes that are directly linked to child mortality rather than to focus on the implementation process.

2.1.3 IMCI implementation in countries

Each country presented their progress in IMCI implementation, highlighting aspects of the strategy that were of particular importance in their settings. Overall, the countries showed considerable achievements. However, most of them raised the issue that resources available for IMCI implementation were very limited.

Viet Nam presented an impressive amount of work done over the last years, including activities relating to IMCI pre-service education and community IMCI, and showed how the necessary resources could be mobilized, while Vanuatu stressed the logistical constraints it is facing given the geographical situation and limited human resources. The experience of Solomon Islands showed how political unrest could threaten IMCI implementation.

The Philippines, like Viet Nam, was among the first countries in the Region to adopt IMCI and the country presentation focused on achievements in the area of pre-service education. Papua New Guinea showed how neonatal care can be addressed through IMCI but it also showed the considerable constraints faced in the implementation of IMCI given the general difficult conditions in the country.

Mongolia's extensive geographical coverage of IMCI implementation was impressive, while Malaysia pointed out the needs for targeted implementation in limited geographical areas and sub-national adaptations. Lao People's Democratic Republic shared information on the progress made in IMCI implementation with very limited human resources. Kiribati, on the other hand, pointed out the importance of implementing all three components right from the start. Fiji was a good example of how good collaboration among different partners and programmes made progress possible 'against all odds'.

China presented the significant progress that had been made in IMCI implementation but also highlighted issues such as disparity between different regions within the country with a childhood mortality rate that is relatively low on national average. Cambodia was an example where support from NGOs can facilitate the implementation of IMCI and this country also elucidated the need to explore possibilities of working with private health care providers.
In the discussions that followed the presentations, inequalities in progress towards the MDG to reduce child mortality (MDG 4) was pointed out again, and participants suggested that the Region could support country efforts in a more targeted way, focusing on the countries in greatest need. It was also stressed that there should be clear and fixed targets to achieve the MDG 4, and progress should be regularly monitored. It was recognized, however, that these targets must be achievable in the context of the country situation. It was also recognized that there was a need for more outcome data and that the focus had to shift from process to outcome. There was an agreement that more innovative ideas for taking IMCI implementation to scale should be generated during this meeting.

2.2 Session 2: Strengthening the teaching of child health

The second session discussed the latest developments in child health, including materials, tools and methods in pre-service education. Countries that had implemented IMCI pre-service education also shared their experiences. The session included two presentations, a field trip, a video presentation and group work on progress in and plans for IMCI pre-service education at the country level.

2.2.1 Planning, implementing and evaluating the teaching of IMCI

The rationale for strengthening the teaching of public health approaches was introduced as it relates to key areas of focus within child health: care of the newborn, infant and young child feeding, IMCI and adolescent health and development. Particularly, the number of deaths during the first week of life is decreasing more slowly than among older infants, and in order to save newborn lives, selected interventions for better neonatal health are needed in pre-pregnancy, during pregnancy, delivery and post-natal care. Among these interventions is improving health workers' skills. The importance of strengthening the teaching of child health as a way to provide a link to real life situations to newly qualified graduates, giving priority to the most serious health problems, and to promote rapid recognition and action were pointed out.

Implementing IMCI pre-service education comprises four major steps as follows:

1. analyzing the situation;
2. planning how to strengthen teaching;
3. preparing teachers, materials and practice sites; and
4. evaluation.

Several challenges to strengthen pre-service education, both at national and institutional level, were discussed. These challenges include reaching consensus on health priorities, strengthening the health system to allow graduates to use newly acquired skills and ensuring coordination of teaching between different academic programmes and units. Global recommendations defining the characteristics of a socially accountable curriculum of competent teachers and students/future practitioners were stressed. It was emphasized that strengthening pre-service education is a phased and cyclic process.

The issue of costs and sustainability when preparing materials at the country and institutional level was also discussed. Teaching, learning and student assessment materials for pre-service education have been developed by WHO and are available. Copies of some of these materials were also distributed at the workshop.
Following the presentation, comments made were on the importance of educating medical students about public health priorities, and the need to prepare the health facilities for the IMCI skilled health workers. In this process, consultations between the institutions and the health system are crucial. Regarding student assessment, it was noted that there is a need for an IMCI standard test since the one that has been developed so far depends on the different methods used by institutions for student assessment.

2.2.2 Field trip to the University of Santo Thomas College of Nursing

The University of Santo Thomas was founded in 1671 and the Nursing College was established in 1946. The Nursing College currently has 1708 students. The nursing programme is a four-year programme. The teaching of IMCI was introduced to the College in June 2002, and the teaching of students started five months later. IMCI was integrated into level three of the second semester curriculum.

The process of developing materials included condensing the IMCI inservice training modules into shorter versions, reprinting the chart booklet, preparing the wall charts and video exercises and printing IMCI forms. Quizzes and examinations in electronic form were developed, and feedback to quizzes was also prepared in electronic presentations. A room to teach and assess practical skills was identified.

Teaching activities consist of classroom teaching, inpatient sessions, skills laboratory practice and outpatient sessions. Students' assessment consists of a written, video and practical examinations. The students obtain an IMCI grade which is one of the criteria for passing the subject.

The workshop participants were divided into several groups to visit the different activities that were going on or were organized as simulations of everyday activities. These included inpatient and outpatient sessions, role-plays and video exercises. The participants had a chance to talk to the students and listen to their questions and comments. The students were generally very happy with the new approach to teaching, and expressed confidence in practising the skills that they had learned.

The participants also discussed with the faculty issues and challenges on the introduction phase of IMCI pre-service education in the college. The College's vertical integration of the IMCI teaching throughout the academic year and the coordination between teaching units was praised. However, the number of clinical instructors per student (1 to 12-14) was thought to be challenging, and the caseload per student (10 patients) seemed low for the practice of the full process of the IMCI guidelines. Challenges in the long run included sustaining the enthusiasm of the teaching staff and ensuring that the graduates can apply IMCI in their practice and contribute to the strengthening of the health system. It was suggested that the teaching staff be provided with further information on the technical basis of the good practice and updated epidemiological data to sustain their enthusiasm.

2.2.3 Capacity building for IMCI pre-service education in the Region

The Global Development Project for IMCI pre-service education and subsequent progress in pre-service education activities in the Region were discussed. Early examples of implementation in Fiji, Mongolia, the Philippines and Viet Nam were discussed.

A summary of the workshop, "Academic Consultation on Pre-service Training in Child Health", that was held in Penang, Malaysia, July 2002, was presented. The Academic Consultation brought together key members of the academe from 12 countries in the Region to discuss the process, experiences and plans for pre-service education in child health with a particular emphasis on IMCI. The meeting facilitated the development of a pool of resource
persons with a good understanding of the process, good knowledge of the tools and materials available and an ability to support national efforts in strengthening child health in countries of the Region.

Following the presentation, monitoring and evaluation issues in pre-service education were discussed. The need for continuing inservice training was also stressed.

2.2.4 Strengthening the teaching of child health in Ho Chi Minh City, Viet Nam

The experience of the University of Pharmacy and Medicine in Ho Chi Minh City that integrated IMCI into the curricula for medical students in year 2000 was presented in a video. Each year 300 medical undergraduate students and 100 postgraduate students graduate. The hospital where the students practice assesses 2000 to 3000 children each day. IMCI is introduced in year four and students practise it in year six. Eight to nine students share two clinical instructors. The video illustrated the IMCI environment and students practice.

It was pointed out that the students in Ho Chi Minh City have good possibilities for practising what they are taught because of the IMCI environment. The teachers had also completed an 11-day IMCI case management course and the five-day facilitators course prior to teaching IMCI in the pre-service setting. The IMCI curriculum is also being introduced into the secondary medical schools in Viet Nam, and it was noted that the teaching materials were the same. The issue of the costs of pre-service education was also brought up; however, it was difficult to give an exact estimate of these costs.

2.2.5 Group work: Progress in IMCI pre-service education at the country level

The objectives of the group work were to review the progress in IMCI pre-service education at the country level against plans prepared at the Academic Consultation on Pre-Service Training in Child Health which was held in July 2002; to identify "success factors" and constraints; to review the country plans and to identify possible areas for support.

The participants worked in 12 country groups reviewing the plans. A summary of the group work highlighted the following issues:

- Good progress had been made in countries such as Fiji, the Philippines and Viet Nam.
- Lack of funds was a major constraint.
- There is a need for more advocacy from professional bodies such as paediatric associations.
- Technical support is necessary.
- Coordination between the Ministry of Health and the Department of Education needs to be improved.

In general, all countries have shown great commitment. Progress is facilitated by:

- general interest in child health and public health;
- enthusiasm among the Deans of the faculties and teachers;
- the establishment of IMCI training units;
• orientation sessions for all teachers in the institutions; and

• knowledge of previous programmes like Control of Diarrhoeal Diseases (CDD) and Acute Respiratory Infections (ARI)

2.3 Session 3: Improving family and community practices

The objective of Session 3 was to review the Regional Framework for Community IMCI, and discuss the way forward in improving family and community practices. The session comprised three presentations and group work. The presentations discussed community IMCI from a global perspective, in the Region and in the community. The group work was on case studies on planning and implementing community IMCI.

2.3.1 Community IMCI in the global context

The third component of IMCI, i.e. "community IMCI", focuses on preventive and caring practices at the household and community level. Reduction in child mortality and morbidity and promotion of child growth and development depend on the availability of a well functioning health system with well trained personnel and the care families and communities provide their children. As health facility utilization rate is often low and many children die at home without having been taken for medical care, health facilities alone cannot provide the solution to children's needs for care. Family and community practices have a great impact on child health.

The 12 key family and community practices cover four main topic areas. These are: growth and development, disease prevention, home case management and care seeking and adherence. Four additional practices covering HIV, prevention of childhood injury, abuse and neglect, and father's involvement in care may be added. The 12 key practices were described and a review of evidence-based research by the London School of Hygiene and Tropical Medicine was introduced.

The main operational principles and steps were presented, emphasising the needs to:

• focus at first on a limited number of key family practices;

• build upon existing programmes, structures and resources;

• strengthen the link between health facilities and communities; and

• promote active community participation and ownership.

Examples of community IMCI efforts in other regions of WHO were provided. This was followed by a description of the planning process, the tools available and under development, and the main interventions such as communication for behaviour change. Indicators that apply to the household level on nutrition, prevention, home case management and care seeking were also described. Challenges included local coordination, the role, motivation and supervision of community health workers, integration of activities at the community level, sustainability, documentation and scaling up. The presentation concluded with two points for reflection: build upon existing tools and activities, and have the courage to start.

In the discussion, participants emphasized the need to simplify messages and concentrate on the important ones. It appeared also that the term "community IMCI" is somewhat confusing to donors and governments in relation to what is already in place. There is also a need to elaborate on the role of local government and linkage with local stewardship, and clarify the role of NGOs in the planning and implementation process of community child health activities.
Regional Framework for Community IMCI

The Regional Framework for Community IMCI was developed through a consultative process with active NGO partners and building on the experiences in community child health in the Region. In this process, a Regional NGO Technical Consultation on Community IMCI was also organized in 2002. The Western Pacific Regional Framework for Community IMCI is to be used as a guide for activities in planning and implementing community IMCI, with an overview of the planning and strategy development process.

The Regional Framework identifies four important areas of community IMCI as partnerships and linkages, community participation, health information and promotion, and the means for improving key practices. These four areas are closely interlinked. Partnerships and linkages will contribute to improving the quality of health care and use of health services, achieving a multisectoral and integrated approach, ensuring appropriate coordination and consistency, and making it possible for community IMCI activities to be sustained and scaled up. Community participation contributes to behaviour change, and information and health promotion lead to improvement of the 12 key family practices through integrated health messages. Community access to necessary health services is increased as a means to improving key practices.

Guiding principles for community IMCI planning and implementation include consultation between partners at all levels, use of participatory processes and the need to build upon activities already in place. The planning process should involve national, provincial and district levels and the key steps include coordination, situation analysis, consensus building and strategy development. At the community level, it is important that the community is represented in the coordination structure. To ensure sustainability, emphasis needs to be placed on capacity building, ownership by the community, and the links to other community development processes and projects right from the start.

Scaling up of community IMCI is essential to have a significant impact on infant and child morbidity and mortality. Early planning after reviewing the pilot implementation experience should take place with allocation of adequate resources, and expansion at the same time of the other IMCI components. Indicators to measure the progress and impact of community IMCI activities need to be relevant to the country and standardized among implementing agencies.

The need for coordination, collaboration and adequate resources for community IMCI was discussed, and it was suggested that a specific logo for community IMCI be developed for advocacy purposes. Child to child was also seen as an important tool for communication of messages. It was pointed out that in some countries, funding is channelled via implementing agencies rather than via the government. More experience will need to be gained on the effectiveness of the interventions. It was recognized that ownership of the community child health activities is one of the most crucial factors in making the efforts sustainable.

Presentation of community experience in Sarangani Province, Philippines

Sarangani Province shared its experience with the implementation of community IMCI and showed that successful implementation of the three components of IMCI can result in good outcomes. The four areas of community IMCI (partnerships and linkages, community participation, health information and promotion, and means for improving key practices) were implemented by building upon existing structures at national, provincial, district and village levels. Monitoring of indicators showed improved outcomes in reduction of under-five deaths and deaths due to preventable causes, nutrition in children under-five, number of children given vitamin A, households using iodized salt, and households with sanitary toilets, and with access
to potable water. Immunization rates however were affected by lack of vaccines, and also there was no improvement in exclusive breast-feeding of infants for six months.

Building on existing structures and systems facilitated acceptance, ownership and accountability of new innovations. By focusing on target groups, indigenous, uneducated, communities with less access to services, showed significant difference in improvement of caring behaviour. Local legislation provided an enabling environment for mobilizing other sectors and additional resources for children. Challenges mentioned were the need to improve volunteer counselling skills, continuous advocacy and the intensification of the quality assurance programme.

In the discussion, Sarangani Province was congratulated on its impressive efforts. Further discussions took place on issues such as sustainability of achievements, and the interplay between the different activities in the three components of IMCI. Also discussed were funding issues, ownership and empowerment of the community, and integration of aspects of the reproductive health programme into child health programmes.

2.3.4 Group work

The objectives of the group work were:

(1) to enable participants to become familiar with the concept of community IMCI and with the Regional Framework for Community IMCI as a guide for planning and implementing community IMCI; and

(2) to enable the participants to discuss the way forward for community IMCI and to reflect upon their roles and responsibilities.

The participants were divided into four groups and discussed the following issues:

- experience in areas of the Regional Framework for Community IMCI: partnerships and linkages, community participation, and means for improving family and community practices;
- opportunities and resources at different levels;
- definition of a national strategy; and
- roles and responsibility of the government.

Groups presented very similar opportunities including existing national structures, organizations and committees, political commitment, legislation, existing budget lines, MDGs, health sector reforms, poverty reduction, and networks of NGOs and mass organizations already working at the community level. The national strategies proposed were based on the current Regional Community IMCI Framework and described components and mechanisms. Government roles and responsibilities were clearly described by some groups and encompassed policy, legislation/laws, coordination, resource generation, guidelines and national indicators, maintaining standards and monitoring quality of projects, equity, procurement and advocacy.

The discussion stressed the importance of building on existing structures and programmes. There is a need to coordinate standard messages with those used by other programmes, as community IMCI is not a separate package but needs to be integrated into existing relevant programmes and strategies opportunistically. Activities at the peripheral level are integrated often by just one health worker, which is often not the case at the national level.
2.4 Session 4: Scaling up and sustainability of IMCI

The objective of the last session was to identify ways to ensure the sustainability of IMCI within the context of child health and health system development, enhance partnerships and outline a plan for resource mobilization and scaling up of IMCI in order to maximize child health outcomes in the Region. The session comprised two presentations, a round table discussion and group work.

2.4.1 IMCI and health systems development

Different components of health system development and health sector reform were discussed. These included policy and legislation, financing, planning and coordination, resource allocation, leadership and management, delivery of health services, education and training, partnership and linkages, clinical and public health services, and the formal and informal health sector. The essential public health functions, the role of stewardship, objectives and key drivers of health sector reform were also highlighted. The important issue of addressing the health of the poor was emphasized. This could be done by focusing, for example, on the conditions affecting the poor in disadvantaged areas, types of services needed, and populations groups mostly affected. The low demand and use of health services in some countries needs also to be addressed by removing barriers, improving quality of care and raising awareness about services available. Proper monitoring and evaluation is important in any setting for the advancement of health systems.

The implications for IMCI were that it should remain flexible in order to be integrated into the ongoing health sector reform programmes, because systems keep on changing with increasing complexity. It should also work within the existing health sector to be sustainable. In addition, the implementation of IMCI should also take into account policy and financing issues because of the impact they can have on successful implementation. Community involvement is also increasingly important, as well as linkages and relationships with other sectors and human resources development. It was also urged that IMCI should be actively fitted into sector-wide approaches.

It was pointed out that 60% of the burden of disease is attributed to child health problems resulting in 40% of service demands, and that 90% of burden of disease is due to the 10 most common causes of childhood illnesses and this accounts for 50% of mortality. Inaccessibility to health services that can deal with these conditions is not always associated with poverty. More innovative service delivery strategies to address difficult situations and minority and disadvantaged population groups are needed, and IMCI should realign with other existing programmes rather than remain a stand-alone strategy. It was also noted that current health information systems seldom meet the needs of primary health care, including the IMCI classification system. Another challenge is the low utilization of services that can hinder the impact of the strategy. Supervision of health care workers and turnover of the staff was determined to be a major human resource challenge in many countries. However, it was suggested that innovative types of supervision, such as self-supervision, should be explored. Alternative mechanisms of health care financing are also needed to fill the gaps in national health budgets. Priority setting is important and child health should be positioned so as to reflect the burden of disease on populations and the health system. However, lack of planning skills is often a reality in least developed countries. It was concluded that cross-sectoral collaboration is needed at the country level, as well as integration of vertical programmes at the district level. Pre-service education was seen as a means for long-term sustainability of the IMCI strategy.
2.4.2 Collaboration among child health related programmes

Four presentations on neonatal care, infant and young child feeding, environmental health and Roll Back Malaria illustrated collaboration among child health related programmes.

Neonatal care was presented as a bridge between maternal and child care. It was emphasized that a mother and baby cannot be separated and a "healthy mother means healthy baby". It was noted that 28 to 30 million babies are born in the Region every year, and that more than 300,000 die during the first day of their life. In the light of these statistics, if the MDG goal of reduction of under-five mortality to two-thirds the 1990 level by 2015 is to be achieved, neonatal mortality needs to be reduced by 50%. Integrated Management of Pregnancy and Childbirth (IMPAC), a strategy similar to IMCI has been developed by the Reproductive Health Programme to address the challenges of maternal and neonatal health, and covers areas of antenatal care, labour and delivery care, and postnatal care. Reducing maternal and infant mortality requires national legislation and policy, coordination, and long-term efforts within the health system and actions from within families and communities.

The 60% of childhood deaths which are associated with malnutrition and inappropriate feeding practices for children under one year old are a major concern. A strong collaboration between the Nutrition Programme and IMCI exist, and a global Strategy for Infant and Young Child Feeding has been developed. Key elements of this strategy include exclusive breastfeeding for six months, appropriate complementary feeding after six months, continued breastfeeding for two years or longer, and special attention to breastfeeding in difficult situations such as a mother with HIV/AIDS or severe malnutrition.

The Environmental Health Programme also interacts with child health in pursuit of developing better environments for children. Some examples include Healthy Cities projects, Healthy Islands approach for Pacific island countries, environmental impact assessments and water and sanitation programmes that are being implemented in many countries.

The Global Roll Back Malaria Initiative is being implemented in malaria-prone countries. The focus of this programme is on improving availability of anti-malarial drugs, microscopic diagnosis and treatment protocols, as well as development of rapid diagnostic tests for peripheral level health facilities.

The need for continuing dialogue with the programmes in all the above-mentioned areas was emphasized. The need for linkages between IMCI and other vectorborne and parasitic diseases programmes was also mentioned. Following the presentations, there were active discussions focusing on the need for functioning referral systems, active community participation and involvement of the private sector in both maternal and child care.

2.4.3 Collaborations with partners for scaling up

This session was organized in a round-table discussion following brief introductions by 14 representatives of NGOs, international donor partners and country delegates, under three general topics:


- targeting and focusing interventions (China, Papua New Guinea, the Philippines, Helen Keller International, UNICEF); and

- improving the visibility of IMCI (Cambodia, Fiji, WHO/Headquarters).
A summary of the round-table discussions is presented in the table below based on the introductions given by the 14 members of the round table and the subsequent discussion.

### Constraints to the initial progress and expansion of IMCI

<table>
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<th>Constraints</th>
<th>Possible Reasons</th>
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| Funding has been negligible compared to the burden of disease being addressed | • Decision-makers/donors are not convinced that IMCI is cost-effective  
• Many competitors for funding  
• Child health has not been promoted as a priority globally or regionally  
• No comprehensive budgeting has been provided to show what resources are needed  
• IMCI has been promoted as a strategy not a programme so many countries do not have a budget line for IMCI |
| Donor (and decision-maker) commitment has been weak or ambivalent          | • It is difficult to explain and “sell” a complex multi-faceted strategy  
• Benefits of integration are not obvious to all – vertical programmes are seen as successful  
• Donors want proof of IMCI’s effectiveness before investing in it  
• Donors are reluctant because they do not see high level government commitment to IMCI  
• For some donors, IMCI is not really community-based and is not yet reaching the people who need it  
• Political figures change frequently |
| Lack of evidence of impact on child mortality                              | • IMCI implementation is still in its early stages and investment has been minimal  
• Mortality impact is difficult to measure over a short time-frame. Impact data is expensive to collect and there is no funding for this  
• Limited resources are spread over too many objectives  
• Initial preparatory steps in IMCI implementation are lengthy  
• The 11-day training course means progress in training coverage is slow  
• Measurement has focused on process indicators  
• Positive achievements have not been documented |
| Lack of significant, visible and convincing health service performance results |                                                                                                                                                   |
| Management/coordination have not been a strong as needed                   | • Most countries have a Focal Point (rather than a Programme Manager) with limited authority  
• Limited funding means IMCI is not attractive to potential partners in countries |
| WHO and UNICEF have not clearly and together promoted IMCI as a priority     | • Within WHO, IMCI has become very broad, losing its initial focus. Sometimes it is presented as addressing the five major killers of children, sometimes as a comprehensive strategy for child health  
• Within UNICEF, IECD is promoted not IMCI (IMCI and IECD compete for funding) |
| There is confusion about the scope and priority of IMCI                    |                                                                                                                                                   |
| The potential of partnerships with NGOs has not been fully developed       | • Governments and NGOs speak a different language and do not make an effort to understand each others constraints  
• The community IMCI approach or label may get in the way, despite common objectives  
• NGOs are under donor pressure to deliver results and cannot always wait for long government led processes |
## Suggestions on how to address the constraints

<table>
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<tr>
<th>Issues</th>
<th>Solutions</th>
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| Convincing donors (and decision-makers) to support IMCI and improve funding | • Make the objectives and expected outcomes clear, and define targets  
  • Use the most impressive outcomes and targets to "sell" IMCI, not the rationale of the strategy itself  
  • Explain that IMCI is composed of life-saving interventions for which there is strong evidence. Present this evidence in simple terms  
  • Refocus IMCI on child survival – use the commitment of governments and all main partners to the MDGs, specifically MDG 4. Explain that IMCI also contributes to several other MDGs  
  • Focus on the core strengths of IMCI that address the major killers of children and on achieving and making visible progress for indicators that are obviously associated with child survival  
  • Define resource needs and define targets for resource mobilization  
  • Adjust requests for funding to particular donor interests within child health  
  • Ensure that IMCI is included in Sector-wide Approaches (SWAPs) and other health system development or health financing projects  
  • Recalculate the cost-effectiveness of IMCI building in the long-term benefits of improving nutrition  
  • Emphasize IMCI's contribution to improving nutrition (nutrition assessment, breast-feeding, complementary feeding and micronutrients)  
  • For local decision-makers, produce evidence of increased utilization of health services, cost reduction (for example, through rational drug use) and improved client satisfaction  
  • Use special events (e.g. National IMCI Day) to raise political support  
  • Acknowledge that IMCI may be different from one country to another. Be flexible and opportunistic and build on existing child health activities  
  • Explain that IMCI (promoted by WHO and, in some countries, also by UNICEF) and IECD (promoted by UNICEF) are complementary approaches to achieving similar goals. Emphasize their core strengths and use interagency teams in countries to promote both. |
| Clarifying the scope and role of IMCI                                  | • Where appropriate, promote the creation of a national child survival (or IMCI) programme, with a dedicated programme manager and government budget line  
  • Advocate for including IMCI interventions in health financing for the poor and social health insurance schemes from their initial design  
  • Focus on areas and populations with high child mortality. Target interventions to the children in greatest need (geographic, socio-economic, ethnic, gender targeting). Make better use of existing data to target IMCI  
  • Explore flexible and innovative approaches for achieving effective training coverage, e.g. adapt training for grass-roots health workers  
  • Make better use of the comparative advantages of different partners including different NGOs. Enlist the support of NGOs to reach underserved areas. Make links with strong civil society organizations  
  • Educate consumers of the benefits of IMCI and what services they can expect  
  • In some countries, shift attention to IMCI in pre-service education for doctors and nurses to ensure long-term sustainability  
  • Measure outcomes not processes to stimulate achievements and provide more convincing evidence for donors and decision-makers  
  • Place greater emphasis on simple, proven interventions and reducing neonatal mortality. Improve links with maternal health programmes. |
2.4.4 Group work

Following the round table discussions, group sessions were organized to discuss further the key issues raised. In a lively discussion that took place, it was concluded that in order to target and focus interventions, baseline data is extremely important. It needs to be disaggregated in terms of geographic areas and age group. Planning at the national level should reflect priority areas for IMCI and the resources needed. Key activities and strategies of implementation also need to be identified. Activities should be phased, completing them in one district before moving on. Core indicators should be agreed upon and reported on regularly.

In order to improve visibility, IMCI should be advocated in every related forum. It should also be linked to MDGs and health sector development. IMCI should be promoted not only at the national level but also at the provincial/district and local levels. Also, professional public relations and advertising groups/firms could be involved to advise for free on campaign, promotional materials and logo design. IMCI being a multidisciplinary approach, the need to collaborate with other interested parties for child survival activities is crucial.

2.5 The way forward in the Region

Based on the rich elaborations on the current status, achievements made and challenges that remain, the participants discussed the future directions of child health in the Region. It was acknowledged that the 3,000 under-five deaths that occur daily in the Region call for intensified child survival action. This is particularly so because most of these deaths are due to preventable and treatable conditions for which evidence-based interventions exist, but their coverage is insufficient to benefit those in greatest need. Political will and appropriate resources have been lacking.

The rationale and content of IMCI was recognized to be valid and based on strong evidence, which is also reflected by the good uptake of IMCI by countries across the Region and by the strong interest to institutionalize IMCI in pre-service education of doctors, nurses and midwives. It was noted that the lengthy introduction and early implementation is completed in many countries, and rapid progress should be possible if funding is available.

New opportunities for intensifying child survival in the Region have been created by the growing commitment to the MDGs including the MDG4 on child mortality reduction, as well as the increased attention recently stimulated by the series of articles in the *Lancet*. The new Director-General of WHO has expressed his commitment to child health, with similar percussions from the top leadership of UNICEF. Also, it is significant that development banks allocate one fourth of project funds to primary health care, and international development agencies are involved in health system development and basic services for children. Furthermore, partnerships had been established with a large NGO community and professional associations have become active advocates for child health. In the Region, the WHO Regional Director is very committed to child health, which will also be on the agenda of the 54th Session of the Western Pacific Regional Committee in September 2003, allowing for an excellent opportunity to further discuss child health among the top policy-makers in the Region.

The topic was concluded by a few action points on the future direction of child health in the Region as follows:

- Focus on child survival. Emphasize that 3,000 children die each day. These deaths can be substantially reduced with simple affordable interventions.
- Define clearly the expected outcomes, and link them to the achievement of the MDGs.
Target the children in greatest need; that is, countries, areas or populations with the highest childhood mortality.

Define a core set of indicators that all countries will report on, and that are easy to understand and that relate to proven life-saving interventions.

Encourage countries to identify a larger set of child survival indicators appropriate to the local context.

Ask all concerned countries/areas to set targets for and report regularly on their “top 10 indicators for child survival” (core regional indicators plus nationally-selected indicators).


Define resource mobilization needs for each country and set targets for a Regional Focus for Child Survival.

Promote IMCI and IECD as the major strategies for child survival but encourage all activities that can contribute to the indicators.

Invest in marketing the new initiative through a variety of regional and national channels.

3. CONCLUSIONS

The main conclusions of the workshop were as follows:

3.1 General

3.1.1 Impressive progress has been made in IMCI implementation in the Region. Twelve countries have embraced IMCI as the strategy to reduce childhood mortality and morbidity, and 11 countries have already passed the comprehensive adaptation process.

3.1.2 Countries are now facing the challenge of scaling up IMCI to maximize coverage of the priority child health interventions covered by the IMCI strategy to promote child survival, growth and development. This requires change. The focus must shift from process to health outcomes that are directly linked to the reduction of child mortality and morbidity.

3.2 Strengthening the teaching of child health

3.2.1 There is a strong interest among and general acceptance of all stakeholders to institutionalize IMCI by including it in the pre-service education of doctors, nurses and midwives.

3.2.2 Teaching institutions provide a valuable setting for promotion, advocacy and visibility of child survival interventions since a large proportion of newly qualified graduates find their first jobs at primary health care level where they provide care to children and counsel caretakers.
3.3 **Improving family and community practices**

3.3.1 Key family and community practices are evidence-based and help promote growth and development, prevent disease, increase use of health services and reinforce messages for health care providers.

3.3.2 WHO, UNICEF, NGO/community-based organizations and other partners assist governments and communities to put key family and community practices in place, albeit through different mechanisms and under different names. There is a need for national coordination for resource generation and maintenance of standards using indicators, as well as enabling health policies that allow collaboration in community child health activities between all stakeholders.

3.3.3 The four elements of the *Regional Framework for Community IMCI* (partnerships and linkages, community participation, health information and promotion, and means for improving key practices) will be the key to improve community and family practices.

3.4 **Scaling up and sustainability of IMCI**

3.4.1 The approach used to mobilize resources for IMCI and other aspects of scaling up should be reviewed by countries and by the WHO Regional Office for the Western Pacific, taking into account the many useful suggestions made by the workshop participants.

3.4.2 The workshop requested that WHO and UNICEF make every effort to harmonize the promotion and implementation of IMCI and IECD strategies to avoid confusion and competition for funds and to enhance their true complementarity.

3.4.3 The workshop requested that the forthcoming Western Pacific Regional Committee of WHO discuss ways of revitalizing and intensifying child survival activities in countries and areas where mortality remains high, in keeping with a commitment to the achievement of the MDG 4.

3.5 **The way forward in the Region**

3.5.1 Any new initiative on child survival, using IMCI and IECD as the main tools, should be well focused in content and well targeted at the most vulnerable children, clearly state the expected outcomes and regularly monitor progress on a key set of indicators.

4. **CLOSING**

In the closing, the WHO Regional Director for the Western Pacific referred to his own experience in seeing the original "sick child initiative" develop from piloting to expansion of interventions. In spite of the magnitude of the problems, i.e., 3 000 daily under-five deaths in the Region, its social cause, and good progress made in countries to expand innovative strategies to deliver life-saving interventions, it seemed that child survival had not reached due attention. He thanked the participants for their frank analysis of reasons for this, and urged the participating countries and the international health community to speak more strongly for children so that the child deaths will have a human face and problems will be better recognized. He also echoed the need for WHO and UNICEF to thoroughly examine the current approaches and come out with one voice, talking the same language, and putting aside all organizational interests. Clearly this would mean deviating from the "business as usual" mentality.
Dr Omi emphasized the importance of child health, and the role of IMCI as a tool to put in practice essential evidence-based interventions. In order to take IMCI to scale, the minimum requirement should be to give explicit evidence on the effectiveness of interventions and progress made to the mass media, political decision-makers, donors etc. in a convincing manner, and strike the emotional core of people. He noted that the lack of resources in child health is well recognized, so the emphasis should be on convincing the ministries of finance or equivalent with data and emotions. While he saw WHO's role to come up with supportive tools such as sales package, national programme managers could, for example, document their success stories for further advocacy in the field.

In closing, Dr Omi informed the workshop that child health will be a high priority for the work of WHO in the Region over the years to come, and that an intensified drive for child survival will be proposed to the 54th Session of the Western Pacific Regional Committee that will convene in September 2003 in Manila.
SECONd WORKSHOP ON
INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS
Manila, Philippines
25-29 August 2003

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## TENTATIVE TIMETABLE

<table>
<thead>
<tr>
<th>TIME</th>
<th>MONDAY, 25 AUGUST</th>
<th>TUESDAY, 26 AUGUST</th>
<th>WEDNESDAY, 27 AUGUST</th>
<th>THURSDAY, 28 AUGUST</th>
<th>FRIDAY, 29 AUGUST</th>
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<tbody>
<tr>
<td>0600</td>
<td>Registration</td>
<td>Session II: Strengthening the teaching of child health</td>
<td>Session III: Improving family and community practices</td>
<td>Session IV: Scaling up and sustainability of IMCI</td>
<td>-Plenary: Progress report on group work</td>
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<tr>
<td>to</td>
<td>1. Opening</td>
<td>6. Planning, implementing and evaluating the teaching of IMCI</td>
<td>12. Community IMCI in global context</td>
<td>17. IMCI and health system development</td>
<td>-Group work (continues)</td>
</tr>
<tr>
<td>1000</td>
<td>(Group photograph)</td>
<td>7. Field trip to University of Santo Tomas College of Nursing -Introducing IMCI into the nursing curriculum in the Philippines</td>
<td>13. Regional Framework for Community IMCI</td>
<td>18. Collaboration among child health-related programmes</td>
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<tr>
<td>1015</td>
<td>2. Presentation and adoption of workshop objectives and agenda</td>
<td>Field trip -University of Santo Tomas College of Nursing (continues)</td>
<td>15. Group work: Case studies on planning and implementing community IMCI</td>
<td>19. Collaboration with partners for scaling up IMCI</td>
<td>21. Plenary: Presentation of group reports and consolidation of draft plan for resource mobilization and scaling up</td>
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<tr>
<td>to</td>
<td>Session I: Progress in child health</td>
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<tr>
<td>1200</td>
<td>3. Global overview</td>
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<tr>
<td>1300</td>
<td>4. Regional overview</td>
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<tr>
<td>1300</td>
<td>5. IMCI implementation in countries</td>
<td>8. Capacity building for IMCI pre-service education in the Region</td>
<td>Group work on community IMCI (continues)</td>
<td>20. Group work: Resource mobilization and scaling up of IMCI</td>
<td>22. Workshop summary and conclusions</td>
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<tr>
<td>to</td>
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<td>9. Video on strengthening the teaching of child health in Ho Chi Minh City</td>
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<td>1445</td>
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<td>10. Group work: Progress in IMCI pre-service education at country level</td>
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<tr>
<td>1500</td>
<td>IMCI implementation in countries (continues)</td>
<td>Group work (continues)</td>
<td>16. Plenary: Presentation of group reports on community IMCI</td>
<td>Group work (continues)</td>
<td>23. Closing</td>
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<tr>
<td>to</td>
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<td>11. Plenary: Feedback on group work and field visit</td>
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<td>1700</td>
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</table>

**COFFEE BREAK**

**LUNCH BREAK**

**COFFEE BREAK**