

Integrated Management of Neonatal and Childhood Illness (IMNCI): Implementation challenges in India

The continued high childhood mortality in the developing regions of the world towards the end of the last century resulting mainly from common childhood illnesses with underlying undernutrition for which interventions have been known, was a challenge for the international medical community. It was time for child health programmes to move beyond single diseases, since many children present with overlapping signs and symptoms of diseases making a single diagnosis difficult, often not feasible nor appropriate. Integrated Management of Childhood Illness (IMCI) was a response to this global challenge. India, which has the largest share of global childhood deaths, was clearly in need of some fresh initiatives to meet its commitment towards the Millennium Development Goals related to child survival. IMCI appeared to be the "panacea" for the ailment. National consultations of the adaptation task force in 2000, rechristened the strategy as Integrated Management of Neonatal and Childhood Illness (IMNCI) and brought neonatal health to the forefront to address the nation's felt need and also for the first time developed a health workers IMNCI package.

Training: Since 2000, with the assistance of the UNICEF/WHO, the government of India has initiated IMNCI training in almost 30 districts across the country for all cadres of

health professionals at the district level. This early experience suggests that saturation of a district in terms of training all the health cadres in the public health system could take 3-5 years, with the present system capacity to train being about 50 personnel a month. Several factors could be identified for the slow implementation - attrition of trainers within district/state, non-availability of clinicians as facilitators for 8-10 days, non-availability of facilities with adequate residential facilities and competing interests at the district level. The optimists may argue that the tardy progress is a phase of the learning curve. Innovations have been attempted within these early intervention districts to accelerate the pace of training. However, the impact of the acceleration on skill transfer and quality of training hasn't been stringently evaluated and caution must be exercised before upscaling the intervention. One must not lose sight of the fact that the existing health system in the country has its limitation and accelerating the training pace could jeopardize the quality of IMNCI's skill based training. The proposed plan of "cascade down" training for its implementation in the country during the tenancy of the RCH phase II and the National Rural Health Mission (NRHM) needs to be brought under the scanner since the global experience for skill transfer using this technique has been none too good.

The greater challenge than the initial training is the follow-up and monitoring of the trained personnel to provide on-job supervision and training. This would require the existing supervisors of the front line workers to be equally skilled in IMNCI and be mobile to perform field visits for supervision for most part of the week. The experience

from the early implementation districts has been a mixed one. Given the existing supervisory skills in the health system, ensuring follow-up supervision, if IMNCI is to succeed, needs innovative thinking for its implementation.

Coverage: A key finding of the multicountry evaluation (MCE) of IMCI was the need to pay attention to coverage and to ensure mothers and children receive interventions if mortality reductions are to be seen (1). The present community behavior pattern in rural India suggests that almost three-fourths of the population initially seek help of the private sector for ill health (2). The IMNCI training in the country at present is essentially targeting the health care providers in the public health system. Unless the large sector of private health care providers are brought into the IMNCI fold, the anticipated improved child survival may either not happen or improve marginally. The challenge is in getting this large sector on board. Is IMNCI through distance education or/and in pre-service training in graduate medical schools, with which the country has been experimenting, the answers to the challenge?

A unique feature of the Health worker IMNCI package is to capture the large number of neonates at home, who otherwise never reach health facilities, by mandated home visits amounting to between 3-7 during the first month of life. The enormous challenge is to make the frontline health care providers deliver this part of the package, which hitherto has never happened.

Health system change: Health system change is a key to the success of IMNCI. IMCI-MCE observations indicate that health system changes must precede or run parallel to IMCI implementation; IMCI does not change health systems. As we accelerate the IMNCI

roll out in the country, we must be clearly aware that health system as it is today cannot help IMNCI achieve its objectives. Health systems reforms must be pursued with the same vigor as IMNCI implementation, if IMNCI is not to be dubbed another failed strategy when the NRHM comes to its close five years down the line.

Lessons from IMCI-MCE on system capacity for adoption of new intervention are critical for us (3). First, the ability of the system to absorb new technologies depends on current capacity utilization. Secondly, the cost of treating a child also depends on the level of capacity utilization, at least in terms of provider time. Thirdly, where patient loads are high it is important to determine if the quality of care required for IMCI can be maintained. All three are system constraints at present. The question that looms large is have we taken the IMNCI plunge doomed not to succeed, or are we ready to take up the gauntlet? The impact of health system limitations on IMCI implementation was not appreciated when the strategy was launched in several countries, but it is now clear that solutions to larger problems in human resources, financing, integrated programme management, and effective decentralization are essential to successful efforts to reduce child mortality (4). The opportunity to innovate and change the health system is now and our success will demonstrate the way forward for the global community.

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