Tools for the Household and Community Component of IMCI

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1. BACKGROUND

The Integrated Management for Childhood Illness (IMCI) strategy has been developed since 1992 by UNICEF and WHO as an integrated approach to the assessment, classification, treatment and counseling of sick children and their caretakers. IMCI is addressed to reducing mortality and morbidity associated with five major causes, namely: diarrhea, acute respiratory infections, measles, malaria, and malnutrition. In addition, the IMCI strategy addresses not a single disease but the child as a whole and forms the basis for new treatment guidelines at first-line health facilities, thereby intending to improve the quality of health care.

Figure 1: Distribution of 500 thousand deaths of children under 5 in the Region of the Americas. 1995

1.1. IMCI: improving equity in child health

The five illnesses which the IMCI strategy seeks to control cause, on average, 1 of every 2 deaths in children under 5 in the Region of the Americas (Figure1). Pneumonia and Diarrheal Diseases are the 2 principal causes of these deaths, each one representing about 20% of casualties in this group. About 19% of all deaths in children under 5 are also associated with malnutrition, being that this ailment is registered as the principal or associated cause of death, especially in deaths due to pneumonia and diarrhea. Meningitis and septicemia, together with illnesses preventable by vaccinate are responsible for about 10% of deaths in the age range.
The weight of these five illnesses as cause of death in children under 5 can mask the great differences that exist between countries in the Region.

In the 11 countries where the estimated Infant Mortality Rate (IMR) is above 40 per 1,000 live births, these diseases represent 60% of deaths, while in countries with IMR under 20 per 1,000 live births, they are only 16% of those who die (figure 2). Deaths from these causes are responsible for up to 80% of mortality in children under 5 in some of the countries, or in regions of those countries.

![Figure 2: Proportional distribution of deaths in children from 1 to 11 months of age in the Region of the Americas. Latest available information](image)

In developing countries with IMR between 20 and 40 per 1,000 live births, on the other hand, the 5 ailments mentioned above are the cause of 45% of deaths in children under 5, which further points to the great inequality existent between developing countries themselves in the Region.

In this way, most deaths from these five diseases which IMCI aims to control occur in a limited number of developing countries (those with the highest IMR), which makes balancing the health situation inequities in the Region a clear priority.

The need to reduce the gap between countries with respect to health conditions in children is one of the fundamental motivations sustaining the design and elaboration of the IMCI strategy. This is particularly so in the knowledge that many of these deaths could have been averted with appropriate and cost-effective intervention measures.

Contributing to the improvement of the general health conditions of children, bringing a better quality of care for the health problems that constitute the main causes for concern and
consultation on the part of parents, are the other motivations sustaining the IMCI strategy, and are no less important.

1.2. IMCI: Improving Quality of Child Care at Health Facility and Community Level

Every day, thousands of children are brought to health services for many reasons which concern the parents. ARI and DD are two of the primary causes of all these consultations, and depending on the country, represent between 40 and 70% of all the outpatient visits of children under 5. Most of these children receive treatment for the symptoms which they consulted for, but on few of those occasions will the visit be used by health personnel to detect other health problems. Preventive measures such as vaccination, education of the parents on care for the child in the home, including nutrition all could be taken at this time.

The loss of opportunities for early detection and treatment of illness and health problems is one of the major characteristics of the functioning of the health services in developing countries. As has been done with the process of vaccinations, this concept, emphasizing the need to treat the child as a whole, can be extended to other aspects of preventive medicine. Signs of illness can be identified that in many cases would allow their timely treatment, where the symptoms were not detected by the parents, or were not the reason for the visit.

The IMCI strategy permits health personnel to reduce the likelihood of these problems. It teaches a method for systematic evaluation of the signs and symptoms of illnesses and health problems which most commonly affect children under five. It helps them consider in this evaluation other problems that are part of the local epidemiological reality. It also includes the systematic evaluation of the vaccination status of the child and his or her nutritional state. This increases vaccination rates and helps childhood growth and development.

Finally, the IMCI strategy includes an important educational component, which helps health personnel evaluate how the parents or caretakers are feeding and caring for the child at home. It gives them tools to strengthen positive habits and point out those which may be harmful to the child’s health.

1.3. IMCI: International Agreement to support its Implementation

The importance of the IMCI strategy as a tool to improve health conditions for children has been recognized by the whole international community. Health authorities of the Region of the Americas, international organizations, bilateral cooperation agencies and Non-Governmental Organizations have all participated in its establishment.

Taking as its basis the initial accord between WHO and UNICEF to support the design and elaboration of the Strategy, PAHO/WHO and UNICEF/TACRO subscribed to a Regional accord to support the process of implementing it in the health services. This accord has allowed a fluid collaboration at the regional, subregional and country levels in the activities where IMCI
is the principal intervention in the achieving of the Goals of the World Summit for Children of September 1990.

In the World Development Report, published by the World Bank in 1993, IMCI is considered one of the most cost-effective public health interventions that can be undertaken by developing countries. This consideration of the strategies potential impact on infant mortality has allowed its incorporation in various countries into the projects that the World Bank and Inter-American Development Bank are undertaking for the reform of the health sector.

The implementation of the IMCI strategy in 8 priority countries of the Region of the Americas is also the goal of the Joint Project between USAID/LAC, PAHO and the BASICS project. The project is designed to accelerate the achievement of universal access to the IMCI strategy in the highest-risk areas of developing countries of the Region where IMR from IMCI illnesses represent more than 50% of the annual deaths in children under 5.

Finally, many NGOs are participating in the Regional and country implementation activities, helping to increase the population’s access to the IMCI strategy further still. IMCI is in many cases incorporated into existing interventions for maternal and child health already in progress.

1.4. Implementation of IMCI in the Region of the Americas

With this in mind, the IMCI Unit of PAHO/WHO is conducting and coordinating the general process of implementation of the IMCI strategy in the countries of the Region. A Regional Plan has been prepared based on the PAHO/UNICEF-TACRO accord. It envisions distinct phases and stages designed to achieve the most rapid possible impact in countries with high IMR.

PAHO will take the lead in developing, organizing, and presenting the Training-of-Trainers courses as well as the clinical case management training courses. This training is aimed at first line health facility workers (physicians and nurses) assigned to major health services. The staff, temporary advisors and the consultants in charge of this important component, will act as facilitators for courses at the sub-regional level, to train selected country representatives on how to implement and replicate clinical case management training at the country level.

As a complement of the above mentioned strategy addressed to human resources development, PAHO has been working in the adaptation of the case management training course to participating countries’ priority health requirements, organizational capacity, and epidemiological profile. This training has created a cadre of planners, clinical instructors, adaptation specialists, and monitoring and evaluation specialists, who in turn are expected to replicate training at the country level.

While the IMCI approach focuses on treatment for management of the sick child, it also directs the health worker to provide some important preventive measures for child health (e.g. immunization, nutrition counseling, and breast-feeding promotion, among others). Thus, the knowledge and skills needed by these workers to introduce the caregivers into the IMCI
approach, are key factors in the strategy’s success. It is believed then, that human resources
development through pre-service and in-training service will provide the required skills to
develop, implement, and sustain the IMCI strategy in the target countries.

2. IN-SERVICE TRAINING

2.1. IMCI Training for Health Auxiliaries

Much of the under-five prevalent disease pathology in rural areas is seen and treated by
nurse auxiliaries and other auxiliary health personnel, many of whom do not have full literacy
and regular reading habits. Among the plans for a near future, the partners in charge of the
IMCI implementation throughout the Region of the Americas have been developing an IMCI
course targeted at lower-level, auxiliary health staff. Development and field testing of the
course was completed in Africa in September 1997. Since a significant portion of child health
care services are provided by auxiliaries in the Latin American and Caribbean target countries,
this IMCI course should prove valuable in the entire region.

Following the development and testing of the IMCI for Auxiliaries course in Africa, it
has been proposed to replicate the experience in Latin America by inviting trainers and
previous IMCI course participants from the Central American countries, Bolivia, and Ecuador to
a technical adaptation workshop at which a Latin American and Caribbean version of the
course can be developed. It has been anticipated that the IMCI for Auxiliaries course will retain
the use of the principal existing IMCI materials while focusing on less print-dependent learning,
self-assessment and peer learning techniques. Following the adaptation workshop, a
Facilitator’s Guide will be available for field testing in one target country with significant
numbers of auxiliary health personnel.

The results of the adaptation workshop and field tests will be disseminated to the other
target countries through a series of sub-regional technical workshops for country trainers. The
results of the Africa experience have already been analyzed by the partners in order to convene
a workshop to discuss results and afterwards perform field tests by the regional personnel and
the field staff. Follow-up technical assistance may be provided by the partners’ technical staff to
operationalize training in target countries if needed.

2.2. Community Health Worker Training

The need for training courses and materials for volunteer community health workers
with limited literacy skills is also a major requirement of the overall strategy to implement IMCI
in the Latin American and Caribbean Region. Community level health worker training
materials have been developed to complement the IMCI approach. Resources from the Regional
IMCI Initiative are been used to contract with a qualified group, to refine, translate, and field
test materials for the development of this course.

In addition, there are other on-going community-level health programs in the Latin
American and Caribbean region (e.g. from Honduras and Peru) which will be examined closely
by the participants partners’ program staff and country representatives to enrich the materials.
The results will then form the basis for the design and implementation of sub-regional workshops for participating country representatives. Technical assistance will be provided to the target countries to adapt the community health methodology and materials for country training.

The main objective of this activity is to design a training course, and appropriate materials, for the health personnel at the community level where the IMCI strategy is being implemented. This module is expected to be developed within the next few months by a multidisciplinary group in Colombia, who is knowledgeable about the IMCI strategy as well as about methods and techniques appropriate for the training of the community health workers.

The module is expected to be tested during the second semester of 1997 in two different sites in two different countries of the Region. Proposed countries to test the module include Argentina, El Salvador, Guatemala, Honduras, Nicaragua, and/or one of the Andean countries. Soon after a generic module is finalized by the middle of 1998, it is expected to be introduced, promoted, and adapted for its use in the IMCI priority countries of the Region of the Americas, before the end of 1998.

2.3. “Talking with the Mother/Caregiver” Module

The implementation of the IMCI strategy calls for the training of health personnel responsible for the treatment of children in the local health services and other outpatient facilities, as well as the training of personnel responsible for the planning of activities at the national, regional, and local levels. This training include the teaching of skills, techniques, and mechanisms on how to properly educate and communicate with mothers/caregivers of children under 5 years of age to improve their basic health knowledge and on how to care for their children at home.

In the Region of the Americas, during the 1997 regional consultant meeting in Montevideo, Uruguay, a document addressing the training of health personnel to better communicate with the mother and/or caregiver was revised and discussed. As a result, it was recommended that a module for the health personnel be prepared to complement the IMCI Clinical Training Course that would address these specific issues.

As a result, a module was developed by a consultant group in Santa Fe, Argentina. PAHO/WHO revised the first version of the document and supported its testing that was conducted May 20, 1997, in Santa Fe, Argentina, with a selected group of health personnel. A second field test was conducted in December, 1998, in the northern region of Argentina; and another one will probably be conducted in El Salvador later on. Soon after these planned field-testing exercises, the module will be introduced, promoted, and adapted for its use in the IMCI priority countries in the Americas.

The module “Talking with the mother/caregiver” aims to improve the countries’ capacity to effectively implement the IMCI strategy. For the mother/caregiver to seek and demand quality services and to comply with health counseling is essential to understand and to know when and where to seek care, as well as the type of care to be given at home. Also,
mothers/ caregivers need to understand and comply with the instructions given to them by the health providers as part of the IMCI protocol, including important health messages, prevention and control measures, and danger signs.

An important component of the module “Talking with the mother/ caregiver” are the examples of everyday situations that may be encountered in the health centers as well as the exercises to practice the learned skills, techniques, and mechanisms to overcome any barriers that may limit the benefit of the IMCI strategy.

3. PRE-SERVICE TRAINING

3.1. IMCI Training for Physicians and Nurses

It is important when introducing a complex and comprehensive health strategy like IMCI to the Latin American Caribbean Region to develop pre-service training modules for physicians and nurses as part of their formal medical education. IMCI clinical training during medical school and a refresher course just before mandatory rural service can educate young physicians and nurses in the use of IMCI protocols.

The previous joint ARI/ CDD Medical Education (MEDED) experience in the Region could be used to design, introduce, and field test IMCI training modules in selected participating countries, and then use the results in sub-regional technical workshops. The end objective is to enable physicians and nurses in key positions at the clinical, management and academic levels to fully adopt the principles of IMCI and include this concept in pre-service training classes. A similar pre-service training tool for health auxiliaries is not being considered under this Initiative because the partners believe that the two proposed community level training courses (health auxiliaries and community health workers) for those with limited literacy skills is more appropriate in the in-service setting.

4. CARETAKER DEMAND AND COMPLIANCE

In order to improve country capacity to implement IMCI, it is believed that caretaker demand for quality services and compliance with counseling are integral elements which must be given high priority. Caretakers need to know when and where to seek care; and what care should be provided at home. In addition, caretakers need to comply with instructions given to them by health providers as part of the IMCI protocol, which provides a number of key health messages about danger signs and home care. What are not clear sometimes are the potential barriers or behavioral disincentives that caretakers face when trying to seek care in a timely way or to implement the recommendations.

PAHO and the partners associated in the IMCI implementation have considerable experience in information, education, and communication (IEC)/ behavior change and communications. This joint experience and evolving tools and methodologies will be adapted for sub-regional replication.
4.1. Communications and Behavior Change for Caretakers

The Latin American and Caribbean experience to define behavioral barriers and develop communications strategies appropriate to IMCI will be analyzed. The focus will be on developing community-level approaches to caretaker education and behavior, utilizing community health workers or other village organizational resources. A technical workshop will be developed for Ministry of Health and NGO representatives to examine the cumulative Latin American and Caribbean behavior change experience and the IEC issues countries must confront if IMCI is adapted as a national child care strategy.

From a predecessor project named the "Tool Box for Developing Health Communications Capacity", there is an available course and materials in Spanish for health communicators which can be useful in designing the technical content of the workshops. The IEC Tool Box for IMCI could be adapted and some one-week sub-regional workshops on the Tool Box could be organized and conducted. Moreover, operations research will be conducted on the use of the Tool Box in two target countries and disseminate results to all countries.

Based on the workshop experience, some limited, targeted IEC/behavior change interventions will then be identify and supported in two early-use target countries. Sub-regional follow-on technical workshops for additional Latin American and Caribbean target countries, to replicate the experience, lessons-learned, and materials developed, will be designed and carried out later this year.

4.2. A Behavior Change Strategy for Providers

From experience we know that doctors and nurses sometimes gloss over the need for proper counseling of caretakers. For cultural reasons, communications between providers and caretakers can be garbled. Health messages are sometimes misunderstood by mothers, and compliance with doctors’ and nurses’ advice becomes problematic. Since caretaker preventive and curative home care, and knowing when to seek outside treatment is often critical, operations research on the reasons or barriers for non-compliance of health providers with recommended IMCI protocols will be developed. The Latin American and Caribbean Regional IMCI Initiative proposes such research in two target countries, the results of which will form the basis for refinement of the IMCI counseling protocol in sub-regional technical workshops. In addition to this approach, coordination with the “Talking with the mother/caregiver” module has to be taken into account to implement to development this component.

To explain this issue in a more conceptual and comprehensive way, some extracts from the Technical Report recently released by the BASICS Project (Basic Support for Institutionalizing Child Survival), Emphasis Behaviors in Maternal and Child Health Focusing on Caretaker Behaviors to Develop Maternal and Child Health Programs in Communities, may be useful:

In order to have a measurable impact on childhood morbidity and mortality in developing countries, public health programs need to focus on health-related behaviors, in particular the behavior of child caretakers.
Previous models to the IMCI strategy results package, such as the so called Pathway to Survival, have been useful to assist with the development and monitoring of integrated child health programs. There are also now good data available from many developing countries to affirm that at least 70% of all childhood mortality results from five major medical conditions: diarrheal diseases, acute lower respiratory tract infections (ARI), malnutrition, malaria, and measles.

Because children often have multiple conditions at the same time, managing just one of these conditions may not prevent their death from other underlying conditions. Programs need therefore to focus on all five of the most common causes of morbidity and mortality (i.e. this is the basis to the technical fundaments for the IMCI strategy implementation).

The process of applying the emphasis behaviors framework for bottom-up program planning involves basically three steps:

- First, health managers need to choose which of the found sixteen emphasis behaviors to focus on their program. They can do this by reviewing existing community-based data on caretaker knowledge, attitudes, and practices and on vaccination coverage rates, and by investigating the feasibility of implementing a program at the community level.

- Second, strategies appropriate for the local context need to be developed to target this subset of behaviors. This process involves: (i) identifying context-specific aspects of the behavior on which to focus, (ii) identifying target audiences, (iii) developing strategies to change emphasis behaviors in these target audiences, (iv) identifying appropriate channels for the messages and developing the messages and materials.

- Third, a monitoring and evaluation plan is required. The subset of behaviors selected by community programs can form the basis for simple program objectives and indicators in order to allow local-level health managers and planners to develop cost-effective programs in communities.

5. INFORMATION, EDUCATION, COMMUNICATION (IEC)

5.1. Exchanges with Health Workers, and with the Community

The success of IMCI implementation depends basically on two factors. Firstly, the effective application of the strategy by health workers. Secondly, on the progressive incorporation of the prevention and promotion aspects by the local community, including the use of personnel and health services trained in IMCI application.

Past experience in implementation of specific control strategies, such as Acute Respiratory Infections (ARI) and Diarrheal Diseases (CDD) has taught some valuable lessons. It has shown that the basic activities for the implantation of the strategy, such personnel training and furnishing supplies for its application, are not sufficient to guarantee the effectiveness of the efforts.
The change of attitude requested of health personnel in adopting new procedures for the management of old problems cannot be achieved solely with the above mentioned activities; other measures are called for.

Interactions between personnel from different levels of the health system, which guarantees the continuing availability of support for the identification and resolution of difficulties and problems affecting the application of the strategies, should be considered an essential activity. As an expansion of the usual concept of supervision, this activity should be incorporated as an essential part of the process of implementation, designed to maintain a continuous flow of information on the problems the strategy intends to control. It also maintains the impact of the application. If used in a systematic way, this activity becomes a part of the component of continuous training and education of the health personnel, and strengthens the inter-institutional bonds of communication.

The need for active participation on the part of the community in the process of planning, implementation and follow-up of the control strategies has also resulted in a very important point for analysis, a mechanism crucial to the future sustainability of the activity. This activity also proposes an expansion of the usual social and educational health communication concepts: the sharing of information pertinent for decision-making and control with all levels of the health structure. This process is also considered part of the continuous education of the community, designed for them to appropriate the knowledge necessary to change lifestyles for healthier growth and development in the community as a social group.

Keeping in mind the lessons learned during the implementation of the strategies of control of ARI and CDD, we should consider the Information, Education and Communication (IEC) component to be an essential element in the IMCI implementation process.

Given IEC’s status as a component, it should not be considered to be a one-time activity within the implementation process. Rather, it should be thought of as a live wire, woven through all the activities, conducting currents of information and reinforcing the connection between them, as well as energizing the results hoped for.

The IEC component is directed on one hand to the health personnel, contributing to their motivation to apply the strategy. It includes diffusion and interchange of relevant information to emphasize the severity of the problems IMCI seeks to control, as well as specific information about those problems in the context of the chosen application procedures. It also includes periodic updates on advances and results, difficulties encountered, and alternative solutions and experiences used in different areas, so as to help local personnel to identify problems and identify resolutions to them. This continual communication process will become a fundamental part of the continuing training and education of the human resources in health.

On the other hand, IEC is directed to the community, instituting the process of locally planning the implementation of the IMCI strategy. In the first phases of this process, IEC is fundamentally geared to exchange information not only from the point of view of the health services, but also from that of the whole community. This makes it possible to realize the adaptations necessary to present the strategy in such a way that people consider it pertinent and
necessary to apply. This is crucial to enrich IMCI’s ability to improve care of children in the home and to detect possible obstacles to the application of preventative measures such as vaccination, administration of vitamin A, breastfeeding and training of personnel responsible for care of children.

In later stages of implementation, IEC fulfills a fundamental role in strengthening positive practices in the care of the child in the home, and in identifying and progressively weakening inappropriate or negative ones. Through targeted interpersonal communication and information exchanges, better results in modifying certain practices and in finding adaptations acceptable to the community within the values and habits of the community can be achieved.

IEC is of fundamental importance as a gateway to other health problems and difficulties in the community, which determine the health condition of the child and family. Conceptualizing the IMCI strategy as an opening to the improving of health conditions generally for the child and its family, IEC is an essential component to provide solutions to the control of other problems that act as determinants for health from the time of conception.

The strengthening of IEC in the implementation process of IMCI at the Regional level is considered a priority by the IMCI Unit of PAHO/WHO. This is why numerous instruments are being designed to support the various levels of the health structure in its systematic incorporation.

5.2. Mechanisms for information exchange

The mechanisms for exchange of information on the problem and its control are multiplying. This provides health personnel with tools to share the problems that they face and to learn new modalities for their solution. The IMCI Epidemiological Bulletin contains information on the magnitude and characteristics of the problem in the Region. It will progressively incorporate partial results of the application of the strategy at the local level where personnel trained in IMCI are already applying the strategy.

The Child Health Dialog/IMCI bulletin, which comes out with greater frequency, is also a source of information on the illnesses and health problems that IMCI is designed to control. It reports on the strategies, characteristics, implementation activities and complementary data on the problem and results obtained.

Initiatives designed to local production of such publications are being launched to consolidate the health service coverage in the countries.

A course designed to strengthen the skills of the health personnel in communicating with mothers and other caretakers of children in the home has been prepared and tested in recent months. It emphasizes the need and importance of progress in communication to guarantee that the community’s benefits from knowledge necessary to improve health practices for children. The preparation of other materials to apply this course at different levels of health personnel, both within and outside of institutions is being planned.
An IMCI course for Community Health Workers (CHW) is also being prepared, to provide the community access to the content of the strategy through people more in tune with the population. This can accelerate the incorporation of lifestyles favorable to the growth, development and nutritional health for the child.

Finally, various materials and methodologies for the interchange of information to be used in interpersonal, group and widespread communication activities, on small and large scales are also being prepared in generic form to be adapted at the corresponding levels as a part of IEC.

6. THE IMCI MANAGEMENT COURSE FOR THE LOCAL LEVEL

The IMCI Unit of PAHO/WHO has initiated the development of a Course for the Organization of the implementation of the IMCI strategy at the Local Level. The course is designed for personnel responsible for control activities that the local level and is oriented to the planning of activities designed to improve health conditions in children based on institutional and non-institutional or community actions.

The implementations of the IMCI strategy is the thematic crux of the course, being that it is considered an appropriate gateway to continually improving child health conditions.

The course is considered essential to strengthen the planning abilities of the personnel working at the local level. It emphasizes actions which will be carried out promoting the use of IMCI by the public, once the health personnel has implemented it.

The course orients personnel’s tasks toward optimal use of available resources not only in the health services but also in the community. Local institutions such as NGOs, elected representatives, churches, etc., as well as the community itself can be involved.

Applying methodologies for local planning, the course provides health personnel with the ability to:

- Organize the functioning of the health services for the service of the population served
- Establish mechanisms for periodic monitoring and supervision of the performance of personnel individually and of the health service as a whole
- Favor participation of the community in local planning, application and follow-up on health promotion activities
- Implant practical and appropriate methodologies for the evaluation of results and the impact of the activities.

These courses would include -but will not be limited to- IMCI components such as the local drug system management. That particular component, for example, outlines how to organize supplies, how to estimate the required amounts and prescriptions of the needed drug according to the morbidity due to ARI, DD and their complications at the national, district, and local levels, and also number and types of cases to be treated, unit and total costs, etc.
The courses will also include a series of indicators to monitor and evaluate the organizational system developed by the health workers in charge of the IMCI strategy implementation within the MCH programs in the countries.

This experience along with the materials related to this organizational system have been used -and are still being used- in some countries throughout the Region of the Americas. They have been the basis of a number of country reports, program evaluations, and operational studies related to drug use and other supplies for ARI, CDD and other programs previously in place throughout the Region.

These background materials from the organizational courses structure and the results from previous studies will be adapted to the IMCI strategy contents to come up with a generic IMCI Management Course by September, 1998, aimed to improve organization of work at the health facility level as well as monitoring and evaluation of this component.