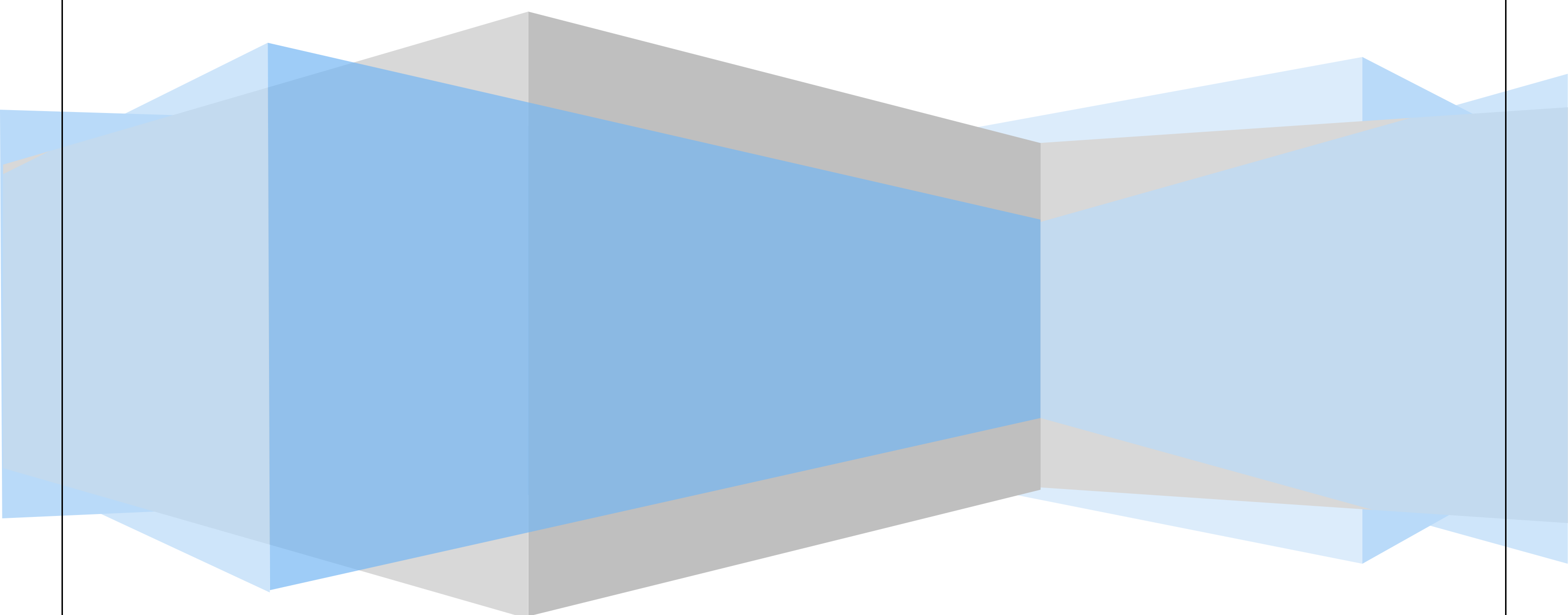
Household and Community IMCI

A Summary Document



Community IMCI

Success in reducing childhood mortality requires more than the availability of adequate health services with well-trained personnel. As families have the major responsibility for caring for their children, success requires a partnership between health providers and families, with support from their communities.

Health providers need to ensure that families can provide adequate home care to support the healthy growth and development of their children. Families also need to be able to respond appropriately when their children are sick, seeking appropriate and timely assistance and giving recommended treatments.

The right to survival and development is one of the four basic principles of the Convention on the Rights of the Child. Human rights principles underlie C-IMCI. The application of human rights principles to IMCI implies that the strategy addresses not only the manifestations of the problem but also the underlying root causes. C-IMCI engages families and communities in discussions about child health and assists them to assess, analyze, and take action on the problems affecting them and their children. It also promotes the participation of parents, other primary caregivers, and communities to sustain new practices that support the changes they have chosen to pursue in child health. Community involvement and capacity development are central to the implementation of C-IMCI.

Key Family Practices

There are **16 Key Family Practices** to decrease mortality and morbidity in children under five and enable children to develop and grow.

For physical growth and mental development

- Breastfeed infants exclusively for at least six months. (HIV positive mothers need special counseling on infant feeding to understand and practice the safest options.)
- Starting at about six months of age, feed children freshly prepared energy-and nutrient-rich complementary foods, while continuing to breastfeed up to two years or longer.
- Ensure that children receive adequate amounts of micronutrients (vitamin A and iron, in particular), either in their diets or through supplementation.
- Promote mental and social development by responding to a child's needs for care through talking, playing, and providing a stimulating environment.

For disease prevention

- Take children as scheduled to complete the full course of immunizations (BCG, DPT, OPV, and measles) before their first birthdays.
- Dispose of feces, including children's feces, safely; wash hands after defecation, before preparing meals, and before feeding children.
- Protect children in malaria-endemic areas by ensuring that they sleep under insecticide-treated bednets.
- Adopt and sustain appropriate behavior regarding prevention and care for HIV/AIDS affected people, including orphans.

For appropriate home care

- Continue to feed and offer more fluids, including breast milk, to children when they are sick.
- Give sick children appropriate home treatment for infections.
- Take appropriate actions to prevent and manage child injuries and accidents.
- Prevent child abuse and neglect and take appropriate action when it has occurred.
- Ensure that men actively participate in providing childcare and are involved in the reproductive health of the family.

For seeking care

- Recognize when sick children need treatment outside the home and seek care from appropriate providers.
- Follow the health worker's advice about treatment, follow-up, and referral.
- Ensure that every pregnant woman has adequate antenatal care. This includes having at least four antenatal visits with an appropriate health care provider and receiving the recommended doses of the tetanus toxoid vaccination. The mother also needs support from her family and community in seeking care at the time of delivery and during the postpartum and lactation period.

Frequently Asked Questions about C-IMCI

- What is the evidence base for the Key Family Practices?
- How do you implement C-IMCI?
- How would the elements be used in terms of programmatic objectives for program planning?
- How did the framework develop?
- How can I learn more about the Framework?
- Where can I find WHO and UNICEF materials on C-IMCI?
- How is C-IMCI different from other community-based programs?
- How does the C-IMCI Framework interact with other health programs?
- How have NGOs implemented the framework?

What is the evidence base for the Key Family Practices?

- Family and community practices that promote child survival, growth and development: A review of the evidence, WHO, 2004. Also available in Spanish

How do you implement C-IMCI?

The C-IMCI Framework enables NGOs and governments to categorize their existing community-based programs and develop a coordinated strategy to improve child health. The Framework includes four categories of activities (called Elements) that all focus on specific behaviors and practices of caregivers of young children and health workers. Each of the elements focuses on an institution, or set of people, with a critical role to play in efforts to promote appropriate child-care, illness prevention, illness recognition, home management, care-seeking and treatment compliance practices. Descriptive, instead of prescriptive, the framework is based on the assumption that C-IMCI will differ from country to country and within countries to respond to local opportunities and needs.

Effective C-IMCI programs:

- **Improve partnerships between health facilities and the communities they serve (Element 1)**
  The first element focuses on increasing the use of formal health services and outreach services through the formation of equitable partnerships that include community input into health services and participation in management of health facilities. Activities under this element include joint village level outreach by community and facility-based providers, collaborative oversight, management and supervision of health services by community committees, and collaboration on community-based health information systems.

  Implementation of this element calls for changes in the roles of both health workers and community members. Health workers need to not only improve inter-personal counseling with clients in health facilities and increase community outreach and education of community members about danger signs requiring care-seeking, but also become more receptive to input from the community, and more accountable for the quality of the services they provide. Through training in quality assurance techniques, health workers can come to see input from the community as constructive and useful, rather than as negative and interfering.

- **Increase appropriate and accessible health care and information from community-based providers (Element 2)**
  Community-based providers are community members and often are the first point of contact for both care of sick children and provision of health information. They include CHWs and other volunteers, traditional healers and midwives, physicians in private practice, and unlicensed providers such as drug sellers or shopkeepers. Together, their practices often surpass the formal health system in terms of patient volume because they may be the most accessible sources of care at the community level.

  A number of disease-control programs and NGO child health programs have worked to improve the diagnostic and treatment skills of these providers. Diarrheal disease control programs worked with CHWs, traditional healers, private physicians, pharmacists, drug shop owners and others to decrease the sale of purgatives, antibiotics, and antidiarrheal drugs and to promote Oral Rehydration Therapy, use of increased food and fluids, and when available, zinc tablets, for children with diarrhea. Malaria control programs have worked with malaria volunteers, shop owners, traditional healers and mothers' groups to promote early treatment of presumptive cases of malaria in the community. Examples of efforts going beyond treatment to engage private providers in prevention include programs that have trained traditional practitioners in Africa to promote HIV/AIDS prevention methods, or to train private and voluntary providers to produce, distribute, and/or sell insecticide-treated mosquito nets.

  Within C-IMCI, it is important to build on lessons learned from vertical programs, while also upgrading the skills of community-based providers to offer the best information and counseling to caregivers. In some cases, PVOs developed simplified IMCI algorithms for use by community-based providers. CARE developed an algorithm in the Siaya District of Kenya and Catholic Relief Services modified the algorithm for implementation in Honduras, the Philippines, and Kenya.

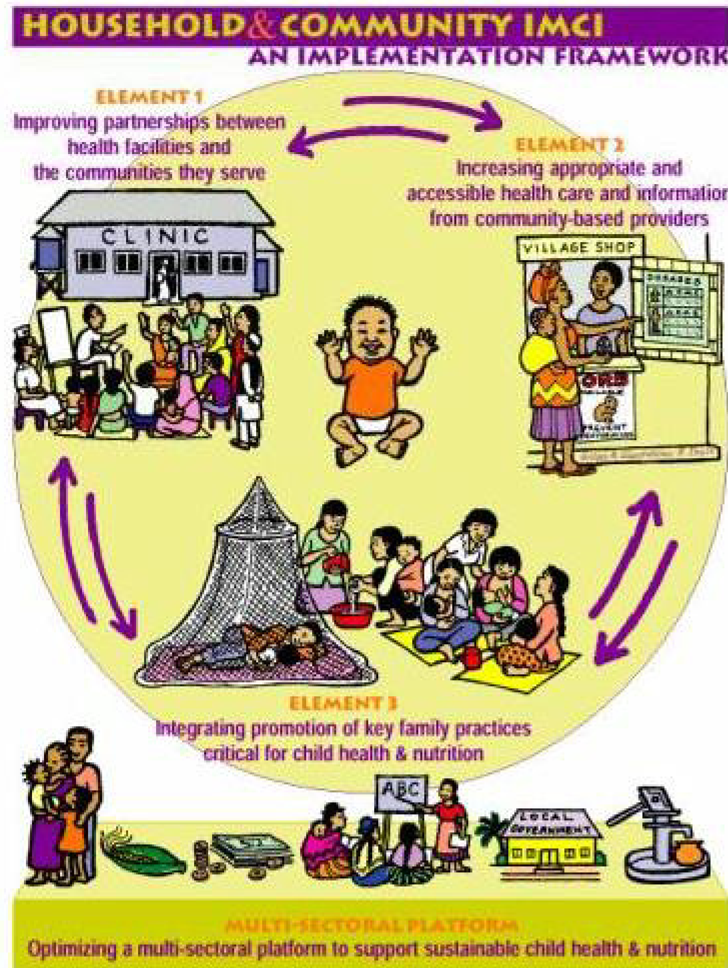
- **Integrate promotion of key family practices critical for child health and nutrition (Element 3)**
  The third element focuses on the practices of the parents and other caretakers of young children at the household and community levels. Promotion of practices critical for child health and nutrition has long been the cornerstone of child health programs. The task facing C-IMCI is not how to implement single interventions or program components such as ORT promotion, immunization or promotion of exclusive breastfeeding, but how a program can promote a whole range of key family practices without sacrificing the effective characteristics of the single-intervention-focused programs. Implementation of this element should incorporate coordinated and strategic use of the mass media through national and regional channels of communication linked closely with behavior change efforts at the district and community levels.

  If C-IMCI is to be effective and sustainable, communities need to be empowered to take responsibility for their own health. For C-IMCI, this means that communities must develop a sense of ownership over the key practices, and assume the responsibility for practicing and promotion them over the long term. Participatory research methods and community-based monitoring and evaluation efforts are

important tools for communities to learn about and assume responsibility for these behaviors.

- **Link health efforts to those of other sectors in order to address the determinants of ill health and sustain improvements in health (Element 4 - Multi-Sectoral Platform)**
  Element 4 reflects the fact that health is intricately linked with other sectors and people may find it difficult or impossible to adopt new behaviors if other problems that they face, such as food insecurity or lack of access to clean water, are not also addressed. Linking C-IMCI to activities in other sectors through a multi-sectoral platform also contributes to the sustainability of health and nutrition activities. For example, when health and education/literacy programs are linked, community members are in a better position to manage and sustain health-related activities over the long term. Additionally, ensuring that services are equitable and reach the most disadvantaged, involves addressing many of the determinants of ill health and focusing on economic, cultural, social, and political factors.

  The Multi-Sectoral Platform (MSP) is an approach that builds partnerships between the health sector and non-health sectors to improve the impact of child health programming in a way that is more effective, efficient, equitable or sustainable than acting alone, and provides positive benefits for all sectors involved.



PDF Versions of the depiction above: English French Spanish

Powerpoint Versions of the depiction above: English French Spanish

CORE developed "A Facilitator's Guide for Conducting Country Meetings on HH/C IMCI." NGOs can use this guide to host workshops designed to increase partner understanding of C-IMCI; develop a common perspective on C-IMCI in order to recognize the potential inputs by all partners; use the framework as a tool for identifying and developing C-IMCI activities across partners and sectors at the local level; and increase cross-organizational and cross-sector collaboration for C-IMCI.

How would the elements be used in terms of programmatic objectives for program planning?

Elements	Examples of corresponding objectives
Element 1: Improving partnerships between health facilities and the communities they serve	○ Form partnerships between health facilities and the communities they serve ○ Increase utilization of health facilities ○ Establish mechanisms for community feedback on and/or management of health facilities
Element 2: Increasing appropriate and accessible health care and information from community-based providers	○ Increase quality of care from community-based providers ○ Increase promotion of preventive practices by community-based providers ○ Decrease harmful practices of community-based providers
Element 3: Integrating promotion of key family practices critical for child health and nutrition	○ Increase adoption of key family practices for health, nutrition and development ○ Engage communities in the selection of behaviors to be promoted and identification of actions to be taken
The **Multi-Sectoral Platform** addresses social, economic and environmental factors that facilitate or hinder the adoption of the key family practices.	

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How did the framework develop?

In early 2000, members of the CORE Group started work on a descriptive implementation framework for C-IMCI based on their experiences in child health and nutrition programs. The Framework was circulated in draft form to CORE members prior to a workshop held in Baltimore, Maryland in January 2001. The workshop included presentations on more than 15 community-based projects across all regions, and allowed participants to critically reflect on the Framework and make suggestions for how to refine it.

- Workshop report
- Workshop presentations

How can I learn more about the Framework?

Several good papers have been written on the framework:

- Reaching Communities for Child Health and Nutrition: A Framework for Household and Community IMCI by Peter Winch, Karen LeBan, Barmak Kusha, et al. CSTS, CORE, BASICS, USAID, 2001. **Detailed explanation** of the framework. (110 pages)

- Reaching Communities for Child Health and Nutrition: A Proposed Implementation Framework for HH/C-IMCI, BASICS and CORE, 2001. **Brief overview** of the framework. (10 pages) Also available in Spanish and French.

- Winch PJ, LeBan K, Casazza L, Walker L, Pearcy K. An Implementation Framework for Household and Community Integrated Management of Childhood Illness. *Health Policy and Planning* 2002;17(4):435-453.

Where can I find WHO and UNICEF materials on C-IMCI?

- Child Health in the Community: Briefing Package for Facilitators
- Community Integrated Management of Childhood Illness - Human Rights Monitoring and Evaluation Resource Pack, UNICEF Eastern and Southern Africa Regional Office, 2004
- Regional Framework for Community IMCI, WHO/Western Pacific Region, 2003

How is C-IMCI different from other community-based programs?

The C-IMCI Framework builds on a rich base of experience in community-based programming over multiple decades. The key difference in C-IMCI and other community-based programming is the integration of diseases, integration with training health providers and strengthening health systems, and the integration across the elements of the framework to address all of the institutions, or people, with a critical role to play in improving child health. Linking these aspects involves intentional design to ensure that efforts carried out at the facility, community and household levels are not isolated. This requires substantive collaboration among public and private, health and non-health sectors.

How does the C-IMCI Framework interact with other health programs?

The Framework can be a point of reference for working with other organizations to develop complementary programs. The first step is to classify the activities of the different programs according to the Framework. Program planners can looks across programs within each Element to identify opportunities for collaboration and coordination of activities. For example, a malaria prevention and control program might classify its activities as follows:

Element	Activities
Element 1: Improving partnerships between health facilities and the communities they serve	○ Collaboration between health services and communities on community-wide vector control. ○ Community input into the timing and location of government health facilities that offer antenatal services along with drugs and insecticide treated nets to prevent malaria.
Element 2: Increasing appropriate and accessible care and information from community-based providers	○ Improved treatment of cases of malaria and promotion of malaria prevention by private providers, shopkeepers and CHWs.
Element 3: Integrated promotion of key family practices critical for child health and nutrition	○ Improved home management of malaria. ○ Promotion and use of insecticide-treated mosquito nets.
Element 4: Multi-sectoral Platform	○ Collaboration with other private sector and micro-enterprise activities on production, packaging, sales, and distribution of drugs, nets, and insecticides.

The Framework can serve to identify gaps in programming that are not being addressed by any current activities in the community and highlight opportunities for better synergy among different programs. Using the above example, program planners might identify opportunities to integrate malaria prevention and control through community-based providers (Element 2) with existing community-based activities related to nutrition, immunization, and HIV/AIDS.

For a table with more examples of linkages between the C-IMCI Framework and other health interventions, click here.

How have NGOs implemented the framework?

Presentations by CORE Group member organizations at the Community IMCI Review Meeting hosted by UNICEF/Eastern and Southern Africa Regional Office in Mombasa, Kenya, 2006.

- World Relief: Scaling Up C-IMCI in Gaza, Mozambique
  Anbarasi Edward (Power Point)
- Plan Cameroon: Child Survival Project
  Pierre-Marie Metangmo (Power Point)
- Community-Based Integrated Management of Childhood Illness: An Introduction to Catholic Relief Services' C-IMCI Training Materials
  Alfonso Rosales (Elluminate Recording), November 2006