

## An implementation framework for household and community integrated management of childhood illness

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This paper describes the development and recent history of the third component of the Integrated Management of Childhood Illness (IMCI) strategy, improving household and community practices (HH/C IMCI). An implementation framework for this third component, developed through review of experiences of non-governmental organizations (NGOs) working in community-based child health and nutrition programmes, is then presented. This Framework responds to demand from NGOs and their partners for a description of the different categories of community-level activities necessary for the implementation of a comprehensive child health and nutrition programme. These categories of activities facilitate the systematic cataloguing, synthesis and coordination of organizational activities and experience. It also serves as a reference tool for improving communication of related community child health activities, and a guide for designing appropriate behaviour change strategies. The Framework was endorsed by participants in an international workshop held in Baltimore, Maryland in January 2001, and specified three linked elements that are integral to HH/C IMCI, supported by a multi-sectoral platform that addresses constraints communities face in adopting practices that promote health and nutrition. The three programmatic Elements critical to HH/C IMCI programmes are (1) improving partnerships between health facilities or services and the communities they serve; (2) increasing appropriate and accessible care and information from community-based providers; and (3) integrating promotion of key family practices critical for child health and nutrition. The Framework presented in this paper is an ideal tool for describing, sharing and coordinating efforts in the field, and is purposely descriptive rather than prescriptive.

**Key words:** Integrated Management of Childhood Illnesses (IMCI), child health services, non-governmental organizations

### Introduction

Deaths in children under 5 years of age continue to account for a large proportion of the global burden of disease. While there has been a decline in under-five mortality from over 13 million child deaths globally in 1980 to about 10.5 million in 1999, there is concern that continued gains will be difficult or be reversed in countries affected by economic instability, deterioration of health systems and high levels of HIV transmission (Adetunji 2000; Ahmad et al. 2000). Five primary causes of illness – pneumonia, diarrhoea, malaria, measles and malnutrition – account for over 70% of child deaths (Tulloch 1999). Awareness of the limitations of disease-specific approaches led the World Health Organization (WHO) and UNICEF to invest in the development of a new strategy known as Integrated Management of Childhood Illness, or IMCI, in the early 1990s (Gove 1997). The IMCI initiative aims to significantly reduce mortality and morbidity associated with these five major causes of disease in children under five, and to contribute to their healthy growth and development.

When first introduced by WHO and UNICEF in Tanzania in 1995, the focus of IMCI was on improving the quality of care in first-level health facilities through introduction of standard treatment guidelines and training of health workers

(Lambrechts et al. 1999). In subsequent years IMCI evolved into a broader strategy consisting of three components (Gove 1997; Lambrechts et al. 1999): (1) improving the case management skills of health workers; (2) improving the health system supports required for high quality care for children coming to health facilities or outreach sites (such as supply of essential drugs, vaccines, equipment and supplies, regular supervision); and (3) improving household and community practices related to child health, nutrition and development. Although sometimes thought of as primarily a set of guidelines for the treatment of sick children, the IMCI strategy goes beyond improving case management of sick children. Interventions in all three components encompass both curative care and disease prevention/health promotion.

The third component, improving household and community practices, is the subject of this article. The third component is referred to as Household and Community IMCI (HH/C IMCI) by the Interagency Working Group (IAWG) charged with charting its implementation, and that term will be retained in this paper. Another common term is Community IMCI (C-IMCI). This third component was officially launched at the First IMCI Global Review and Coordination Meeting in September 1997 (WHO/CHD 1997; Lambrechts et al. 1999). Meeting participants recognized that improving the quality of care at health facilities through IMCI training

of health workers and improvements to health services would not be sufficient to reduce child mortality and morbidity.

### Defining the content of HH/C IMCI

The development of the first component of IMCI, improving health worker skills, was facilitated by the existence of standard treatment guidelines and training modules for diarrhoea, acute respiratory infections, malaria, measles and malnutrition. These guidelines were developed by previous disease-specific control programmes and were incorporated into the standard 11-day IMCI training course for health workers.

HH/C IMCI has been more difficult to define. The equivalent of 'standard treatment guidelines' does not exist for the third IMCI component, improving household and community practices. Initially there was lack of agreement on both the practices to be targeted and the strategy for promoting these practices. A common frustration voiced by many has been 'I still am not sure what Community IMCI is'. While the diversity of opinions and varied definitions of this third component offered at international meetings is stimulating, it can be a barrier to effective advocacy for child health and nutrition programmes. Organizations and programmes often have no clear idea of what the technical content of HH/C IMCI is, and are therefore reluctant to commit resources towards its implementation or to label it as 'Community IMCI'.

As an aid to planning of HH/C IMCI programmes, WHO and UNICEF developed 'The Key Family Practices'. At the Durban meeting in June 2000, consensus was reached on a list of 16 key family practices, as shown in Box 1 (UNICEF 2000). These 16 key family practices, based on scientific evidence and country experience, are the backbone of the HH/C IMCI strategy. The list of 'practices' or behavioural objectives is divided into four groups: (1) practices for physical growth and mental development, (2) practices for disease prevention, (3) practices for appropriate home care and (4) practices for seeking care. A systematic review of the evidence for a list of 'emphasis behaviours' that includes most of the Key Family Practices was conducted by the BASICS Project in 1997 (Murray et al. 1997), and evidence for many of the practices was also reviewed in a recent research meeting (Kelley and Black 2001). There has been considerable input into the list at different workshops and meetings (CORE 1999; UNICEF 2000), and WHO is currently completing a review of the evidence for the current list of key family practices (Hill et al. 2001). While the 16 key family practices define 'what' HH/C IMCI is to target, determining 'how' to implement HH/C IMCI has been more problematic with implementing organizations adopting a variety of approaches.

UNICEF, designated as the lead agency for the third IMCI component, places IMCI within the broad context of an early childhood development strategy. This strategy focuses on empowering communities to analyze and address factors that affect child health, nutrition and development. They advocate that integrated community approaches conform to the Convention on the Rights of the Child and contribute to efforts to reduce the effects of poverty. UNICEF has

**Box 1.** List of key family practices adopted by WHO and UNICEF (List presented at The International Workshop on Improving Children's Health and Nutrition in Communities, Durban, 20–23 June 2000)

#### For physical growth and mental development

- Breastfeed infants exclusively for at least 4 months and, if possible, up to 6 months. (Mothers found to be HIV positive require counselling about possible alternatives to breastfeeding.)
- Starting at about 6 months of age, feed children freshly prepared energy- and nutrient-rich complementary foods, while continuing to breastfeed up to 2 years or longer.
- Ensure that children receive adequate amounts of micronutrients (vitamin A and iron, in particular), either in their diet 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 a full course of immunizations (BCG, DPT, OPV and measles) before their first birthday.
- Dispose of faeces, including children's faeces, safely; and 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 behaviour regarding prevention and care for HIV/AIDS affected people, including orphans.

#### For appropriate home care

- Continue to feed and offer more fluids, including breastmilk, 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.

developed 'community dialogue' tools such as the IMCI PRA (Participatory Rapid Appraisal) (Cornwall and Jewkes 1995) tool adapted for use with HH/C IMCI in Uganda and Malawi. The IMCI PRA tool uses participatory research methods to work with communities to assess and analyze the situation of children, identify factors that facilitate or impede the 16 key

family practices, and identify community resources that can be mobilized to promote child health and nutrition. The PRA process results in community action plans for promoting key practices and also addresses other problems identified by the community, with support from governmental and non-governmental institutions or resources. Initial country experiences have shown that this process has effectively mobilized communities to take action to improve their children's well-being (Tulloch 1999; Claeson and Waldman 2000).

WHO focuses on the initiation, strengthening and maintenance of the key family practices and on the best strategies to address immediate community needs to reduce child mortality and morbidity, including improving the communication and counselling skills of health workers with community clients, and improving the skills of community health workers (CHWs). The Pan American Health Organization (PAHO) built on years of experience with CHW programmes in Latin America to develop a series of training courses, guidelines and other tools for CHWs. These courses and guidelines are a modified and streamlined version of the IMCI guidelines and tools developed for facility-based health workers. Simplified case management, such as the administration of oral rehydration therapy (ORT) for diarrhoeal disease cases, is taught to CHWs, but the system is predicated on recognition of danger signs and referral to health facilities for treatment. Finally, WHO has developed a briefing package for consultants on HH/C IMCI that will enable them to introduce HH/C IMCI into a country. This briefing package focuses on a step-by-step process to introduce the HH/C IMCI strategy, select key family practices, mobilize key MOH health personnel and select prioritized early implementation districts and communities.

#### **NGO interest in developing a descriptive framework for HH/C IMCI**

Child health and nutrition is a long-standing focus of US-based NGOs, particularly during the past 15 years. A major contributor to building their expertise in this area has been the Child Survival grants programme of USAID's Bureau for Humanitarian Response, Office of Private Voluntary Cooperation. These grants have increased the capacity of US-based NGOs to plan, implement and evaluate child survival interventions at the community, district and national levels in collaboration with Ministry of Health teams and local NGOs. NGOs are a key partner in the development of HH/C IMCI programmes and strategies as a result of their cumulative experience and ability to implement programmes on the ground. They have a long-term presence in communities, often work with the most under-served populations, and bring to the table linkages at the local, national and international levels.

NGOs have found that the tools and approaches developed by UNICEF, WHO and PAHO have some utility to settings where they are implementing child health and nutrition activities, but also have important limitations. One is that they tend to describe one component of a programme or one strategy, but do not provide a larger context or framework for activities at the community level. Secondly, they usually

provide prescriptive 'step-by-step' instructions for implementation in an area where activities at the community level are being introduced for the first time or reinvigorated, and thus are much less applicable to settings where NGOs have a long-standing presence. NGOs were looking for a descriptive framework for HH/C IMCI that draws on the cumulative insights and expertise of the NGO community with the implementation of programmes at the household and community levels. There was demand for a framework that would describe the different categories of community-level activities necessary for the implementation of a comprehensive child health and nutrition programme, which allows organizations to build on (or better articulate) activities they are already engaged in. These categories of activities would facilitate the systematic cataloguing, synthesis and coordination of programmatic efforts while promoting a common language between the MOH and NGOs to assist in focusing and coordinating joint efforts.

The CORE Group (Child Survival Collaboration and Resources Group), a network of US-based NGOs, represents NGOs in many different fora. After the 1<sup>st</sup> International Meeting of IMCI in 1997, the CORE Group formed a Working Group on IMCI, sent representatives to Inter-Agency Working Groups on IMCI, and convened several meetings on IMCI (CORE 1999). In early 2000, members of the CORE Group started work on a descriptive implementation framework for HH/C IMCI based on their experiences in child health and nutrition programmes. The Framework was circulated in draft form to CORE members prior to a workshop held in Baltimore, Maryland, from 17–19 January 2001 entitled 'Advancing PVO/NGO Technical Capacity and Leadership for Household and Community IMCI' (Steinwand 2001). The workshop was organized by the CORE Group and the BASICS II Project with support from USAID and the Child Survival Technical Support project. 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.

The revised Framework, based on input at this Workshop, is presented in the next section. The Framework is described in more detail in a document that can be downloaded at the websites of the Child Survival Technical Support project ([www.childsurvival.com](http://www.childsurvival.com)), the CORE Group ([www.core-group.org](http://www.core-group.org)), and the BASICS II project ([www.basics.org](http://www.basics.org)) (Winch et al. 2001). Figure 1 presents an overview of the Framework.

#### **Programmatic elements in the Framework**

Participants at the workshop agreed on three categories of activities and named them programmatic Elements to distinguish them from the three Components of IMCI. The three programmatic Elements all focus on specific behaviours and practices of caretakers of young children and health workers (Figure 1). 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 (Table 1).



Figure 1. Implementation Framework for Household and Community IMCI

At the base of the Framework, supporting all the health and nutrition activities it contains, is a *multi-sectoral platform*. Inclusion of this platform recognizes that achieving sustained improvements in health requires addressing determinants of ill health such as poverty, illiteracy and lack of access to water and sanitation.

The *first programmatic Element* is 'Improving partnerships between health facilities and the communities they serve'. This 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 builds on previous programmes such as the Bamako Initiative (Knippenberg et al. 1997), and calls for changes in the roles of both health workers and community members. Health workers need to not only improve inter-personal counselling 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 Management Methods and other techniques, health workers can come to see input from the community as constructive and useful, rather than as negative and interfering (Heiby 1998).

The *second programmatic Element* is 'Increasing appropriate and accessible care and information from community-based providers'. These providers are community members and are often the first point of contact for both care of sick children

**Table 1.** The three programmatic elements in the HH/C IMCI Framework

Elements	Examples of corresponding objectives
<b>Element 1</b> Improving partnerships between health facilities (and services) and the communities they serve	<ul style="list-style-type: none"> <li>• Form partnerships between health facilities (and services) and the communities they serve</li> <li>• Increase utilization of health facilities/services</li> <li>• Establish mechanisms for community feedback on and/or management of health facilities/services</li> </ul>
<b>Element 2</b> Increasing appropriate and accessible care and information from community-based providers	<ul style="list-style-type: none"> <li>• Increase quality of care from community-based providers</li> <li>• Increase promotion of preventive practices by community-based providers</li> <li>• Decrease harmful practices of community-based providers</li> </ul>
<b>Element 3</b> Integrated promotion of key family practices critical for child health and nutrition	<ul style="list-style-type: none"> <li>• Increase adoption of key family practices for health, nutrition and development</li> <li>• Engage communities in the selection of behaviours to be promoted and identification of actions to be taken</li> </ul>

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 (McCombie 1996; Makinen et al. 2000; Tawfik et al. 2001).

A number of disease-control programmes and NGO child health programmes have worked to improve the diagnostic and treatment skills of these providers. Diarrhoeal disease control programmes worked with CHWs, traditional healers, private physicians, pharmacists, drug shop owners and others to decrease the sale of purgatives, antibiotics and anti-diarrhoeal drugs and to promote ORT for children with diarrhoea (Jinadu et al. 1988; Nations et al. 1988; Bhuiya 1992; Nichter and Vuckovic 1994). Malaria control programmes have worked with malaria volunteers, shop owners, traditional healers and mothers' groups to promote early treatment of presumptive cases of malaria in the community (Kaseje et al. 1987; Mburu et al. 1987; Okanurak et al. 1991; Oshiname and Brieger 1992; McCombie 1996; Okanurak and Ruebush 1996; Gomes et al. 1998; Marsh et al. 1999; Kidane and Morrow 2000). Examples of efforts going beyond treatment to engage private providers in prevention include programmes that have trained traditional practitioners in Africa to promote HIV/AIDS prevention methods (Green et al. 1995; Green 1997; Nations and de Souza 1997; Somse et al. 1998), or to train private and voluntary providers to produce, distribute and/or sell insecticide-treated mosquito nets (Fraser-Hurt and Lyimo 1998).

Within HH/C IMCI, it is important to build on lessons learned from vertical programmes, while also upgrading the skills of community-based providers. The latter should be

based on the same principles that underlie clinical IMCI, such as the classification and treatment of all the problems of a sick child and not just the presenting complaint. Case studies were presented at the workshop in January 2001 of programmes that had conducted such integrated training in Kenya and Nepal (Dawson 2001; Steinwand 2001).

The *third programmatic Element* is 'Integrated promotion of key family practices critical for child health and nutrition', and 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 programmes. The task facing HH/C IMCI is not how to implement single interventions or programme components such as ORT promotion, immunization or promotion of exclusive breastfeeding, but how a programme can promote a whole range of key family practices without sacrificing the effective characteristics of the single-intervention-focused programmes. Implementation of this Element should incorporate coordinated and strategic use of the mass media through national and regional channels of communication linked closely with behaviour change efforts at the district and community levels.

Advocates of participatory assessment and planning argue that if HH/C IMCI is to be effective and sustainable, communities need to be empowered to take responsibility for their own health. For HH/C IMCI, this means that communities must develop a sense of ownership over the key practices, and assume the responsibility for practicing and promoting them over the long term. Participatory research methods (Cornwall and Jewkes 1995; Bhattacharyya and Murray 1999) and community-based monitoring and evaluation efforts are important tools for communities to learn about and assume responsibility for these behaviours.

### Multi-sectoral Platform

The workshop in January 2001 defined HH/C IMCI as 'the optimisation of a multi-sectoral platform for child health and nutrition that includes three linked requisite elements' (Steinwand 2001). Inclusion of the Multi-sectoral Platform in the Framework reflects the fact that health is intricately linked with other sectors and people may find it difficult or impossible to adopt new behaviours if other problems that they face, such as food insecurity or lack of access to clean water, are not also addressed. To achieve sustained improvements in health may require addressing many of the determinants of ill health and wellbeing. Participants at the workshop stressed the need for flexibility in implementing the comprehensive approach implied by the Multi-sectoral Platform, taking into account available resources, local needs and capabilities.

Linking HH/C IMCI to activities in other sectors through this Multi-sectoral Platform also contributes to the sustainability of health and nutrition activities. When income generation is linked to the distribution and sale of insecticide-treated mosquito nets, community members are better able to continue to afford them once external inputs end. When health and education/literacy programmes are linked, community members are in a better position to manage and sustain health-related activities over the long term.

### Linkages between the HH/C IMCI Implementation Framework and other health programmes

When IMCI was first introduced, it was anticipated that it could be a mechanism for countries to bring together various vertical programmes addressing the health, nutrition and developmental problems of young children into one integrated programme. This vision has not been completely fulfilled. In many countries, IMCI has been perceived to be a new categorical programme, and may co-exist with other disease-specific child health programmes. This leads to communities and health workers taking part in participatory rapid appraisal one week for HH/C IMCI, then activities for breastfeeding promotion or malaria control the next, rather than seeing HH/C IMCI as an umbrella concept that includes breastfeeding promotion and malaria control.

The HH/C IMCI Framework presented in this article can be a point of reference for working with other organizations to develop complementary programmes. The first step is to classify the activities of the different programmes, many of which are on-going NGO efforts, according to the Framework. Programme planners can then look across programmes within each Element to identify opportunities for collaboration and coordination of activities. For example, a malaria prevention and control programme might classify its activities as follows:

*Element 1: Improving partnerships between health facilities (and services) and the communities they serve*

- Collaboration between health services and communities on community-wide vector control.

- Community input into decision-making about prevention of malaria in pregnancy through antenatal clinics in government health facilities.

*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 traditional healers.

*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.

*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 programmes. Using the above example, programme 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.

### Principles underlying the HH/C Implementation Framework

Participants at the workshop in January 2001 were concerned that some people might interpret the Framework as a rigid set of rules defining what is right and what is wrong in programming at the community level. Participants therefore elaborated a set of principles to encourage and foster flexibility and creativity in the implementation of HH/C IMCI (Steinwand 2001; Winch et al. 2001). They specified that HH/C IMCI can be implemented at a national, district and/or community level, as appropriate, and that it can be implemented by multiple actors working together. They also recognized the importance of curative and preventive interventions in the community for reducing child mortality and morbidity.

Participants did not want people to feel that HH/C IMCI is an all-or-nothing proposition. While all three elements were felt to be integral to HH/C IMCI, they stated that phased introduction of the Elements and the Key Family Practices is acceptable, and even preferable in many cases. In addition, participants specified that HH/C IMCI can be implemented with or without the first two IMCI Components mentioned earlier in the paper: Health Worker Skills and Health System Supports. The intent of this statement is to enable the immediate implementation of effective community efforts to improve child health and development. IMCI is most effective when all three Components work synergistically. Where Components 1 and 2 are absent, an important focus of HH/C IMCI efforts should be advocating for health services.

### Initial experience with the Framework

The HH/C IMCI Implementation Framework has been presented to Ministries of Health in Latin America/Caribbean and Africa, and to numerous NGOs throughout the world. The Ministries of Health (MOH) in Bolivia and Mozambique have adapted and used the Framework to explain their national HH/C IMCI strategy. In the HH/C IMCI strategy advocated by WHO in the African Region, the framework now forms the core of the strategy, around which are various specific activities to be implemented. The presentation of the Framework has been well received to date, and in each country programme planners have taken the time to discuss the significance of each Element and the Multi-sectoral Platform and how they need to be adapted to their own specific context.

From November 2001 to January 2002, the CORE Group surveyed its members on their experiences with the Framework. The NGO members of CORE perceived that the Framework is valuable because it has provided them with a common Framework for describing their current activities, discussing child health issues with partners such as the MOH, designing and prioritizing strategies to address specific district and community situations, explaining HH/C IMCI to those who previously had not understood it and articulating a vision for community-based child health work. NGOs reported that they plan to use the language of the Framework in preparing proposals for funding, integrating their activities across different programmes, and expanding and sustaining HH/C IMCI activities within their organizations.

### Conclusions

NGOs have begun to design programmes that incorporate the three Elements and the Multi-sectoral Platform, but evaluation of the impact of the application of the Framework on child health efforts will be a long-term process. While the Framework provides a useful reference for a vision of HH/C IMCI implementation, many people want to 'see' what one looks like in the field. Case studies and country examples based on the Framework will be critical in the future. Well-designed evaluation research is needed to convince more practitioners about the value of the Framework. Many MOHs have not invested in community-based health strategies and do not have the skills and systems in place to implement them effectively. This places a greater burden on NGOs to provide examples of what can be accomplished through well-designed community-based programmes.

WHO and UNICEF drew from the tools and approaches of the categorical disease control and nutrition programmes for diarrhoeal diseases, acute respiratory infections, breast-feeding, immunization and others in developing the IMCI strategy. In terms of implementation, however, IMCI, and specifically HH/C IMCI, is distinct from this previous generation of categorical programmes. Rather than being represented as a distinct programme within a Ministry of Health with its own personnel and administrative structure, IMCI is intended to be a strategy for building bridges between different units in the Ministry of Health, and

between the MOH and other partners at the district and community levels. This intent, however, is frequently not understood. Health officials have come to expect that new initiatives from international organizations result in new programmes with their own budgets and personnel, and that these initiatives are introduced at the central level and subsequently implemented at the regional and district levels until they finally reach the community level.

To some extent these expectations on the part of health officials were met with the implementation of the first IMCI component 'Improving the case management skills of health workers'. Implementation requires a process of adaptation of standard treatment guidelines to local conditions at the central level before the guidelines are disseminated through training of health workers, starting with the training of master trainers at the central level.

The implementation of HH/C IMCI has frequently resulted in a clash of expectations. Health officials have expected a step-by-step protocol for implementation starting from the central level. Another expectation has been that previous programmes and initiatives such as the Bamako Initiative, immunization and malaria control would be unaffected by the introduction of HH/C IMCI and continue to operate as they were. Many NGOs and other community-based organizations have been disappointed when health officials proceed to implement new top-down efforts that don't build on existing community-based programming and fail to involve NGOs in planning efforts for effective community programming.

The descriptive Framework for HH/C IMCI presented in this paper has been found to be a valuable tool for building on the experiences of NGOs and community-based organizations in promotion of child health and nutrition at the household and community levels, and complements other tools and approaches that are introduced first at the national level. As NGOs move forward in implementing HH/C IMCI and document their lessons learned, the Framework will continue to evolve and be further clarified. Documentation of different approaches to implementation of the three Elements is crucial, and will allow programme planners to appreciate the options before them as they seek ways to implement child health and nutrition interventions at scale.

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