Original Article

Integrated Management of Childhood illness and Health System Reforms In Pakistan

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ABSTRACT:

Objective:

To draw attention towards IMCI implementation in Pakistan, and to present arguments emphasizing the IMCI implementation on capacity building at district level

Methods:

This article is based on published and unpublished data relevant to IMCI implementation in Pakistan and in other developing countries from 1993-2002.

Results:

In Pakistan non-governmental organizations and private organization are actively involved in IMCI masters training program. The Government of Pakistan had also pilot tested IMCI in two districts of Pakistan, where it has altered the practices of health care provider and showing positive results.

Conclusion:

Introduction of the IMCI strategy presents an opportunity for Pakistan to develop or update National Policy under Health System Reforms for the case management of sick children, complimentary feeding and breast feeding counseling, micronutrient supplementation and vaccination. Implementation of the IMCI strategy will bring

together a broad range of programs and national medical expertise relating to child health. (Rawal Medical Journal 2003;28:44-47).

Key words: Integration, childhood, illness, mortality, morbidity, developing countries, Pakistan.

Introduction:

The IMCI strategy clearly focuses on the child as a whole rather than single disease. The core of efforts of this strategy is to reduce childhood mortality and morbidity and significantly improve children's health in the developing world. It focuses on five most important causes of childhood deaths: Acute respiratory infections (ARI), diarrhea, measles, malaria and malnutrition. These five conditions account for over 70% of the 11.5 million deaths annually, and 80-90% of sick child consultation in developing countries (1).

Effective IMCI requires action at different levels of the health service at home and community, through improving the coordination and quality of services provided by current child health programs. The IMCI strategy will increase the effectiveness of care and at the same time reduce costs (2,3). IMCI has potential to make a major contribution to health system reform. For Pakistan to make this new approach workable demands a degree of innovation and flexibility throughout the existing child health services (4). Implementation of the IMCI strategy involves three components: improvements in the case management skills of health staff, improvements in the health system needed to allow effective management of childhood illness, Improvement of family and community practices. These components will be supported by the proper planning of program, selection of indicators, setting of targets and by evaluation (5).

Every year some 12 million children die before they reach their fifth birthday, many of them during the first year of life. Seven in every 10 of these child deaths are due to diarrhea, pneumonia, measles, malaria or malnutrition and often to a combination of these. Every day, millions of parents seek health care for their children, taking them to hospitals, health centers, pharmacists, community health care providers and traditional healers. At least three out of four of these children are suffering from one of these five conditions (6).

The rationale for implementation of IMCI in Pakistan is high childhood mortality and morbidity. Every year 700,000 children die (6) and most of them because of very common problems like measles, malnutrition, ARI, diarrhea and other vaccine preventable diseases. For a number of reasons, health planners have not paid attention to the health needs of children in Pakistan. Nearly half (43%) of the population of Pakistan comprises of children 15 years of age which account 60% of national morbidity and one of the highest infant mortality in the region, 84/1000 live birth (6,7,8). IMCI had been introduced in 80 countries and implemented in 19 and some indirect indicators endorsed its validity as a comprehensive and effective strategy (9,10). A study conducted in two low-income dwellings in Pakistan showed that where IMCI Guidelines are implemented, it altered the practices of private providers (11). In Pakistan decentralization provides opportunity to improve health care system of the country. The IMCI approach can be an important component of this reform and there is

dire need to pay attention on implementation guidelines so that the quality of child health care can be improved at lower cost by involving family and communities.

Methods:

The article is based on data collection from published and unpublished information, sources relevant to the IMCI strategy in Pakistan and other developing countries from 1993 to 2002. The published and unpublished documents of the Aga Khan Health services (AKHS) and the Government of Pakistan Ministry of Health were utilized.

Results:

The approach gives attention to prevention of childhood disease as well as to treatment. It emphasizes the importance of immunization, vitamin A supplementation if necessary, and improved infant feeding, including exclusive breast-feeding. Wastage of resources is reduced because children are treated with the most cost-effective intervention for the childhood illnesses. The approach avoids the duplication of effort that may occur in a series of separate disease control programs (5).

According to the World Bank's World Development Report 1993, management of the sick child is the intervention likely to have the greatest impact in reducing the global burden of disease. This approach alone is calculated to be able to prevent 14%

of that burden in low-income countries and is among the most cost-effective health interventions in both low-income and middle- income countries.

In many developing countries some type of reform of the health system is

underway (12), and Pakistan is among one of them. It includes decentralization of management, including responsibilities for training and drug supplies. The emphasis in IMCI implementation on capacity building at district level is compatible with, and can contribute to, this aspect of health system reform. Another aspect of health system reform

being promoted in some countries is “essential services” or a minimum package of activities. There is a strong rationale for including IMCI in such an approach (13,14). Pakistan is in introductory phase of the program incorporating IMCI as early as possible in the planning for health sector reforms, using potential entry points such as quality assurance, capacity building, decentralization, and effective health information systems. Currently Pakistan is going through the phases of decentralization and devolution and it is the right time to incorporate this new strategy.

There are constraints to implementation and expansion but they are inherent in the system and are not specific to IMCI. The challenge for us now is to use IMCI to overcome these chronic problems measuring the cost and effectiveness of IMCI.

Discussion

The World Health Organization ranked Pakistan 122 out of 191 countries (12) on “ over all health system performance.” It clearly indicates the needs for improvement in health system, which can be achieved through health system reform. An important focus of IMCI is health system reform and objective of this reform is to improve efficiency of health care system (12). The emphasis of IMCI on the importance of the peripheral levels of the health system, on the quality of care and on strengthening of district management makes it a natural component of health sector reform, by stimulating and providing a focus for essential change.

The emphasis on quality of care and the role of the community is well matched with the stimulus that IMCI gives to the development of the district health system. The response from Africa and some other developing countries have been quite encouraging about

IMCI and development of district health system. The IMCI initiative has been jointly launched by the WHO/ UNICEF in close liaison with the Ministry of Health and aims to improve child care at primary care facilities and the community level. Pakistan is one of the three countries in the world where the IMCI has been modified to include the neonatal period. This initiative was largely indigenous and based on perceived needs. The Government of Pakistan is currently pilot testing the IMCI in two districts and the AKHS has also adopted the IMCI model for its primary care activities. Pakistan may also be a site for the evaluation of the recent Integrated Management of Pregnancy and Childbirth (IMPAC) package. In Pakistan non-governmental organizations and private organization are actively involved in IMCI masters training program. The AKHS Program has conducted a workshop in Karachi where health workers, doctors and other health staff have been trained according to the IMCI guidelines and it has also been implemented at some field sites and showing quite positive results. The Government of Pakistan had also pilot tested IMCI in two districts; Multan and Abbotabad (15), further stabilization and making program successful requires rigorous efforts and commitment from Government as well as from private sector.

For this a concerted effort should be made to bring the advantages of IMCI to the attention of policy-makers, providers, professional association, NGOs, the private sector, the donor community and the public at large. First we need to develop capacity building for doctors, paramedics and community health workers in the districts. Then, work hard on improving monitoring drug system, and supervision. Most important is the strengthening community participation component of IMCI, which improve child care practices, promote care-seeking behavior resulting in increased utilization of the health

facilities. This is important to set our priorities according to the specific situation of our country

Research on family and community behavior aims to develop interventions to promote the prevention and improved management of childhood illness at home. Priority areas are investigating interventions related to care seeking behavior, compliance with health worker advice, infant and child feeding, domestic hygiene practices, immunization practices etc. The estimated 17 languages groups in Pakistan only hint at the complexity of the Pakistani society. Therefore, it is important to consider people from different ethnic background and their behavior and attitudes in terms of whether they are urban or rural, rich or poor, literate or illiterate, and male or female. One must also take into account the religious dimensions. The history of health sector initiatives in Pakistan is replete with examples of programs that would have done better if there had been proper study of baseline attitudes and practices prior to the introduction of the program.

Recommendations and conclusions:

We need to introduce IMCI into our communities and train all the related workers. We need to review existing programs to control diarrheal diseases, ARI, malnutrition and malaria. We have to collect and provide local data to present true situation to the decision makers that IMCI is cost-effective. We have to develop clear indicators and integrated

monitoring and supervisory tools, conduct periodic evaluation of IMCI activities for future planning and continuing activities. Last but not the least, we have to encourage ministry of health to include IMCI in the budget and mobilize donors to support IMCI activities.

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References:

1. Lulseged S. Integrated management of childhood illness: a review of the Ethiopian experience and prospects for child health. Ethiopian Medical Journal 2002 ; 40: 187-201.
2. Rowe K A. Hirnschall G. Lambrechts T. Bryce J. Linking the integrated Management of childhood illness and health information system classifications: issues and options. Bulletin of the World health Organization.1999; 77: 988-995.
3. Integrated management of childhood illness: assess and classify the sick child age 2 months up to 5 years. Geneva, World Health Organization, 1997.
4. New methods to treat infants. Dawn- National; 16 December 2001.
5. WHO. Fact sheet: Reducing mortality from major childhood killer diseases. Fact sheet No. 180. September 1997.
6. UNICEF. The State of the World's children. New York: UNICEF, 2001.
7. UNICEF. The progress of Nations. New York: UNICEF, 1996.

8. Human Development in South Asia, 1997, Oxford University Press, Pakistan.

9. Lambrechts T, Bryce J, Orinda V. Integrated Management of Childhood Illness: a summary of first experiences. Bull World Health Org 1999; 77: 582-592.

10. Ratwari AK, Raina N. Integrated management of childhood illness (IMCI): A robust strategy. Indian J Ped 2002; 69: 41-48.

11.Luby S, Zaidi N, Rehman S, Northrup R. Improving Private practitioner sick- child case management in two urban communities in Pakistan. Trop Med Internat Health 2002; 7: 210.

12. Asian Development Bank. Health sector reform in Asia and the Pacific: options for developing countries. Manila: ADB, 1999.

13. Cassels, A. Health sectors reform in developing countries: Key Issues in less developed countries. (Discussion Paper No.1.) Geneva: WHO, 1995.

14. Berman, P. Health sectors reform in developing countries: Making health system sustainable. Boston: Harvard School of Public Health, 1993.

15.United Nations Population Fund. Government of Pakistan/UNFPA Sixth country Programme 2000-2003. Islamabad, Pakistan: UNFPA1999.