GOVERNMENT OF MALAWI

IMCI APPROACH POLICY FOR ACCELERATED CHILD SURVIVAL AND DEVELOPMENT IN MALAWI

Scaling up of high impact interventions in the context of Essential Health Package

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Contents

FOREWORD

Infant and young child mortality remains unacceptably high in developing countries including Malawi. Most of these deaths are due to five preventable and treatable conditions namely malaria, pneumonia, diarrhoea, measles and malnutrition and often to a combination of these conditions. Lessons learnt from vertical programmes have demonstrated that even though these had made significant contribution to the reduction of childhood morbidity and mortality, most children present with multiple conditions. This necessitated integration of child health initiatives in order to have maximum benefits.

In response to the above, WHO in collaboration with UNICEF developed the integrated management of childhood illness (IMCI). IMCI is an integrated approach to child health that focuses on the well-being of the whole child. IMCI aims to reduce death, illness and disability and to promote improved growth and development among children under 5 years of age. IMCI includes both preventive and curative elements that are implemented by families and communities as well as by health facilities.

Malawi adopted the IMCI strategy in 1998 and implementation started in 1999. There was no policy to guide implementation during the early phase. This made it difficult to coordinate activities at all levels. To address this gap, the Ministry of Health in collaboration with Ministry of Women and Child Development coordinated the development of IMCI policy to guide implementation, provide guidance and mobilise resources. The development of this policy involved wide consultations with government ministries, non governmental organizations, health regulatory bodies, and training institutions. It has to be born in mind that to meet the needs of the child for survival, growth and development requires contribution from various sectors. This demands multi-sectoral collaboration of the responsible partners.

The policy seeks to attain the millennium development goal number four of reducing childhood mortality by 2/3 by the year 2015. It has been developed in the context of the Malawi Growth and Development Strategy (MGDS), Human Rights based Approach to Programming (HRAP), Essential Health Package (EHP) and Sector Wide Approach (SWAp).

The policy covers the main areas addressed by IMCI namely; effective case management, pre-service training, health systems support, promotion of family and community key child care practices. The policy also addresses cross cutting issues such as management, financing and human resources, research, communication, monitoring and evaluation of activities at all levels.

This policy therefore underscores the importance of investing in children as an investment in human capital, which is necessary for sustainable development. I, therefore, urge all stakeholders to support the policy in order to meet the desired results.

The whole exercise would not have been possible without the technical and financial support from WHO, UNICEF and MSH. Finally, the Ministry would like to thank individuals and institutions for their contributions made towards successful completion of the IMCI policy document.

Mrs. Majorie Ngaunje
Minister of Health

ENDORSEMENT

We, the undersigned do hereby endorse the IMCI Policy, its contribution to the survival, growth and development of children in particular and to the development of our nation in general. We pledge our support and commit our Ministries to work harmoniously in implementing this policy.

……	**……**
Mrs. Adriana Mchiela	**Dr. Patrick Kabambe**
Secretary for Women and Child Development	**Secretary for Agriculture and Food Security**
Date: ……	**Date: ……**
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Mr. Grain Malunga	**Mr. Joseph Matope**
Secretary for Water and Irrigation Development	**Secretary for Education**
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Dr W.O.O Sangala
Secretary for Health

LIST OF ABBREVIATIONS

ADC	Area Development Committee
CBCC	Community Based Child Care
CBO	Community Based Organization
CHAM	Christian Health Association of Malawi
C-IMCI	Community - Integrated Management of Childhood Illness
CSD	Child Survival and development
CSDC	Child Survival and development Committee
DEC	District Executive Committee
DHO	District Health Office
DTWG	District Technical Working Group
EHP	Essential Health Package
FAO	Food and Agricultural Organization
FBO	Faith Based Organization
HDR	Human Development Report
HRAP	Human Rights Approach to Programming
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Presumptive Treatment
ITN	Insecticide Treated mosquito Net
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MDHS	Malawi Demographic and Health Survey
MEGDS	Malawi Economic growth and Development Strategy
NGOs	Non Governmental Organizations
ORT	Oral Dehydration Therapy
PRSP	Poverty Reduction Strategy Paper
SP	Sulfadoxine-Pyrimethamine
SWAPs	Sector Wide Approaches to Programs
TA	Traditional Authority
TWG	Technical Working Group
UNICEF	United Nation's Children Fund
VDC	Village Development Committee
WFP	World Food Program
WHO	World Health Organization

1.0 INTRODUCTION

Children under five years of age bear a disproportionately higher burden of disease and death than adults in the world. Globally, nearly 11 million child deaths occur every year, most of them (98%) in the world's poorest countries in sub-Saharan Africa and Asia. Seven in ten deaths (70%) in children under-five can be attributed to one or a combination of the following: diarrhea, acute respiratory infections (especially pneumonia), measles, malaria and other fevers, and malnutrition. Malnutrition is associated with 54% of all child deaths. Recently the HIV and AIDs infection is becoming a more important child health problem. Many HIV positive children actually die from common childhood illnesses. Some of these deaths are preventable by early diagnosis and appropriate management.

In response to this challenge, the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) developed the integrated management of childhood illness (IMCI) strategy, which is an approach to reduce childhood mortality, morbidity and disability in developing countries and to contribute to improved growth and development of children under-five years of age. It encompasses improving case management skills of health providers (components 1), the health system (component 2) and family and community practices. Currently infant and young feeding, essential neonatal care, pediatric care for HIV and AIDS and prevention of mother to child infection have been incorporated in the IMCI training manuals.

This policy is about Integrated Management of Childhood Illness (IMCI), which focuses on the common childhood illnesses. IMCI has three components: component 1: improvement in case management skills of health workers; component 2: improvement in the health system to deliver essential drugs and supplies; and component 3: improvement in family and community practices for child survival, growth and development.

This policy provides guidance and standardization to the implementation of IMCI in Malawi. Its formulation involved reviewing existing policy documents, plans, household survey results, guidelines and in-depth consultations with partners. It has been formulated in the context of major reforms such as, decentralization, Sector Wide Approach (SWAps), Malawi Economic Growth and Development Strategy (MEGDS), Poverty Reduction Strategy Paper (PRSP), Essential Health Package (EHP) and Millennium Development Goals (MDGs).

The process of policy formulation involved development of a preliminary draft by the Technical Working Group (TWG). The draft underwent a comprehensive review process through a series of consultative and consensus building meetings with Directors and Programme Managers from government, (Health, Women and Child Development, Agriculture, Education, Water and Irrigation), Regulatory Bodies, Non-Governmental Organizations (NGOs) and Development Partners. Finally the policy was endorsed by the relevant ministries.

2.0 BACKGROUND INFORMATION

2.1 Country profile

Malawi is a landlocked country in Southern Africa. It is bordered by Mozambique, Tanzania and Zambia. The country covers an area of about 118,500 square kilometers with a savanna type climate, having dry and rainy seasons. The altitude ranges from 1,000 to 3,000 meters above sea level. Administratively the country is divided into three regions: north, central and southern; with 28 districts.

Based on the 1998 population census, the 2005 estimated population in Malawi is 12 million, with approximately 14% (1.68 million) of people living in urban areas. Children under five years of age constitute 17% (2.04 million) of the population and women 15-49 year old constitute approximately 22% (2.64 million). The life expectancy at birth is estimated at 37 years for males and 39 for females. Maternal mortality is estimated at 985 per 100,000 live births (MDHS, 2004). The average household is about 5.3 people per household, with an estimated 1.9 million households. The literacy rates in urban and rural areas are 45% and 23%, respectively.

Malawi's economy is predominantly agro-based, with most people deriving the livelihoods from subsistence farming. Sixty-five percent (7.8 million) of the people live below the poverty line (on less than one dollar per day), with the poor of the poorest constituting 30% (3.6 million). The country is ranked fourth from the last on human developmental index with per capita income of US$177 (Human Development Report, 2004).

2.2 Disease Burden

Globally there are 12 million under-five deaths annually, mainly occurring in developing countries. In Malawi neonatal, infant and young child mortality remain unacceptably high, with 16,000 neonatal deaths, 45,600 infant deaths and 271,320 under-five deaths occurring annually. Most of these deaths are due to neonatal sepsis/infection, asphyxia, hypothermia, malaria, diarrhea, pneumonia, malnutrition and often a combination of these conditions. However, in the past five years, the infant and child mortality rates have reduced from 104 to 76 per 1000 and from 189 to 133 per 1000 live births respectively (MDHS, 2004).

Malaria accounts for 40% (4.2 million episodes of illness) of all outpatient visits. Anaemia, most of which is considered to be attributed to malaria, is estimated to be responsible for about 40% of all under five hospitalisation and 40% of all hospital deaths in under five children (World Bank report 2000). Upper respiratory tract infections contributes 12% (1.26 million episodes), and diarrhea diseases, 7% (730,000 episodes). Malnutrition is endemic with 60% of the children chronically malnourished. In addition the HIV and AIDs epidemic has exacerbated these conditions, it is estimated that 80,000 children < 0-14 years are infected with HIV and less than 5% (6,000) are on Anti-retroviral therapy. A follow up survey on family care practices that promote child health and development (2004) revealed that 60% (163,000) of under-five deaths are occurring at home. The main contributing factors include distance to the health facilities, poor health care seeking behavior, poor hygiene practices and non compliance to health worker advice.

2.3 Status of IMCI in Malawi

IMCI strategy was adopted in Malawi in 1998 with technical support from WHO and UNICEF. By the end of 2005 it was being implemented in 18 districts, 13 (46.4% of districts) implementing all the three components; 4 (14.3%) only components 1 and 2; and 2 with only component 3 (7.1%). There are 9 (32.2%) districts without IMCI. In the 17 districts with components 1 and 2 there are 2,064 health workers of which 1,220 (60%) have been trained on IMCI. It has been introduced into the pre-service training of 16 institutions in which 99 (77%) tutors have been trained. Eleven districts have implemented Component 3 in 39 Traditional Authorities (TAs) out of a total of 161 in the districts.

A follow up survey of Community IMCI (C-IMCI) conducted in 2004 and compared to the 2000 baseline, revealed the following: breastfeeding improved from 25% to 55%; sleeping under ITN by children under five increased from 38% to 65%; vitamin A supplementation among under five children increased from 49% to 65%; there has been an increase in community facilities for water, sanitation, hygiene, but with reduced hygiene practices; measles immunization, by first birthday improved from 75% to 96%; mothers who received second tetanus toxoid (TT2) during previous pregnancy decreased from 94% to 50%; children with diarrhea offered same or more fluids Oral re-hydration therapy (ORT) improved from 39% to 76%, same or more food improved from 8% to 47%; children with fever treated with Sulfadoxine-Pyrimethamine (SP) at home increased from 18% to 22%; and knowledge of danger signs: Caregivers knowledge of at least two danger signs improved from 20% to 40%.

The main constraints and challenges are inadequate financial resources to implement the package as a whole in all districts; acute shortage of staff at health facility level; inadequate referral and communication systems; frequent stock-outs of essential drugs and supplies; and inadequate coordination and inequitable allocation of resources resulting from lack of interest by partners.

3.0 RATIONALE FOR THE POLICY

IMCI policy has been formulated to:

- Provide guidance and standardization in the implementation of IMCI multi-sectoral response.
- Bind all partners involved in IMCI, including the Government of Malawi, multilateral and bilateral agencies, non-governmental organizations, research and training institutions, the civil society, the private sector, service providers and communities.
- Enhance integration of holistic services focusing on children and the household
- Form a framework for managed partnership and coordination
- Promote equitable allocation of resources towards the attainment of MDG number four in a synergistic and accelerated manner.

4.0 VISION, MISSION AND OBJECTIVES OF THE IMCI POLICY

4.1 Vision

The vision of the IMCI policy is to keep all children in Malawi healthy and free from all common childhood illnesses so as to survive, grow and develop to their full potential.

4.2 Mission

The mission of IMCI policy is to provide holistic and integrated services for the survival, growth and development of children under-five years of age.

4.3 Goal

The goal of the IMCI policy is to contribute to the reduction of childhood morbidity and mortality by two thirds between 2000 and 2015 in Malawi.

4.4 Objectives

The objectives of the IMCI policy have been stated as results:

(1) All children suffering from common illnesses managed holistically at out-patient and in-patient of health facilities and at home.
(2) All health facilities have at least two IMCI trained health service providers; supplied with all essential drugs and supplies; and have adequate transportation and communication systems for effective management of common childhood illnesses.
(3) Eighty percent of households practice all the key care practices of IMCI.
(4) All IMCI partners support efforts to scaling up and maintain universal coverage of a standardized minimum package of maternal, newborn and child high impact interventions using the IMCI approach through a managed partnership.

Specific objectives of the IMCI policy will be elaborated in the Strategic Plan and by sectors and partners.

5.0 GUIDING PRINCIPLES

The following shall be the guiding principles in the interpretation and translation of the IMCI policy into strategy and action plans:

(1) Milestones towards the achievement of global and national targets for IMCI implementation will be directed by the MDGs and the human rights based approach to programming.
(2) IMCI will be implemented in the context of the EHP and SWAP.
(3) Operational decision making process of IMCI services will be decentralized to local assembly and the community levels to ensure acceleration of universal coverage.
(4) The implementation of IMCI shall take into consideration multiplicity of partners involved in the delivery of IMCI services.
(5) This policy shall be implemented taking into consideration the available policies and programmes addressing child survival and development issues.

(6) There shall be transparency, accountability and good governance in the provision of IMCI goods and services by all stakeholders.

6.0 POLICY STATEMENTS

6.1 On all components of IMCI

(1) Government shall ensure that all the three components of IMCI are scaled up concurrently to all districts within the context of EHP to achieve universal coverage (80% minimum).

(2) Given the scarce-resource setting in Malawi, the Government shall ensure that IMCI scale-up puts priority in the implementation of a minimum package of high impact interventions (**Annex 2**), taking into consideration the preventive, curative, social and mental development interventions in the package. In a Lancet Series (Child survival, 2003) high impact interventions were defined as those proven to (a) reduce the exposure to infection or condition or (b) reduce the likelihood of exposure that leads to disease, and (b) both preventive and treatment approaches that reduce the likelihood that the disease or condition will lead to death. The series evaluated interventions that address deaths by cause for 42 countries with 90% of worldwide under-5 deaths in 2000.

(3) Organizations or implementing partners that are not able to implement the package on their own should identify complementary partners so as to implement the minimum package at district level.

(4) All agencies and institutions that have a role in IMCI shall include the relevant aspects of IMCI into their pre-service training curriculum.

(5) The IMCI policy shall recognize all the existing policies addressing or related to the elements in the minimum package of high impact interventions.

6.2 Component 1: Case management skills

The Government policy on case management is that:

(1) All sick children under the age of five must be examined for general danger signs, which indicate the need for immediate referral or admission to a hospital.

(2) Irrespective of the presenting complaint, all sick children must be routinely assessed for cough or difficult breathing, diarrhea, fever, and ear problems for children aged 2 months up to five years and, in addition, for bacterial infection (indicated by bulging fontanels, redness around umbilical area and skin pustules) for young infants aged 0 to 2 months.

(3) All care givers whose children may fall ill are counseled on how to give treatment, when to return to health facility immediately, and when to return for follow up.

(4) All under-5 children with severe illness or classification shall be given appropriate pre-referral treatment and referred to the next level of care.

(5) Trained Health Surveillance Assistants shall provide treatment for uncomplicated illnesses at home within their recognized mandate.

(6) Government of Malawi and its partners shall adopt five-day training on IMCI case management for in-service training.

6.3 Component 2: Health systems

The Government policy on improving health systems is that:

(1) All first level health facilities, including outreach clinics, shall have all essential and pre-referral drugs and supplies for the management of sick children at all times.

(2) All first level health facilities shall have at least two health workers trained on IMCI case management.

(3) All first level health facilities shall have readily available transportation and communication system for effective referral.

6.4 Component 3: Family and community practices

The Government policy on improving family and community practices is that:

(1) All partners shall promote the implementation of the minimum package of high impact interventions at household and village/community levels.

(2) Promotion of family and community practices should take advantage of existing and facilitatory community structures.

(3) The policy shall recognize all the existing policies addressing or related to the elements of the family and community key care practices.

(4) Community dialogue in general shall be introduced at the village level for sensitization and mobilization, ensuring that this is immediately followed by the availability of goods and services related to the package.

7.0 KEY STRATEGIC ISSUES

7.1 Institutional framework

The implementation of this policy will require the participation of multiple partners. The following partners will have a direct role and responsibility: Ministry of Health; Ministry of Women and Child Development; Ministry of Agriculture and Food Security, Ministry of Education, Ministry of Irrigation and Water Development, Local Assemblies, Donor Partners, United Nation agencies, Christian Health Association of Malawi (CHAM), NGOs, Faith Based Organizations (FBOs), Community Based Organizations (CBOs), Village Development Committees, Training and Research Institutions.

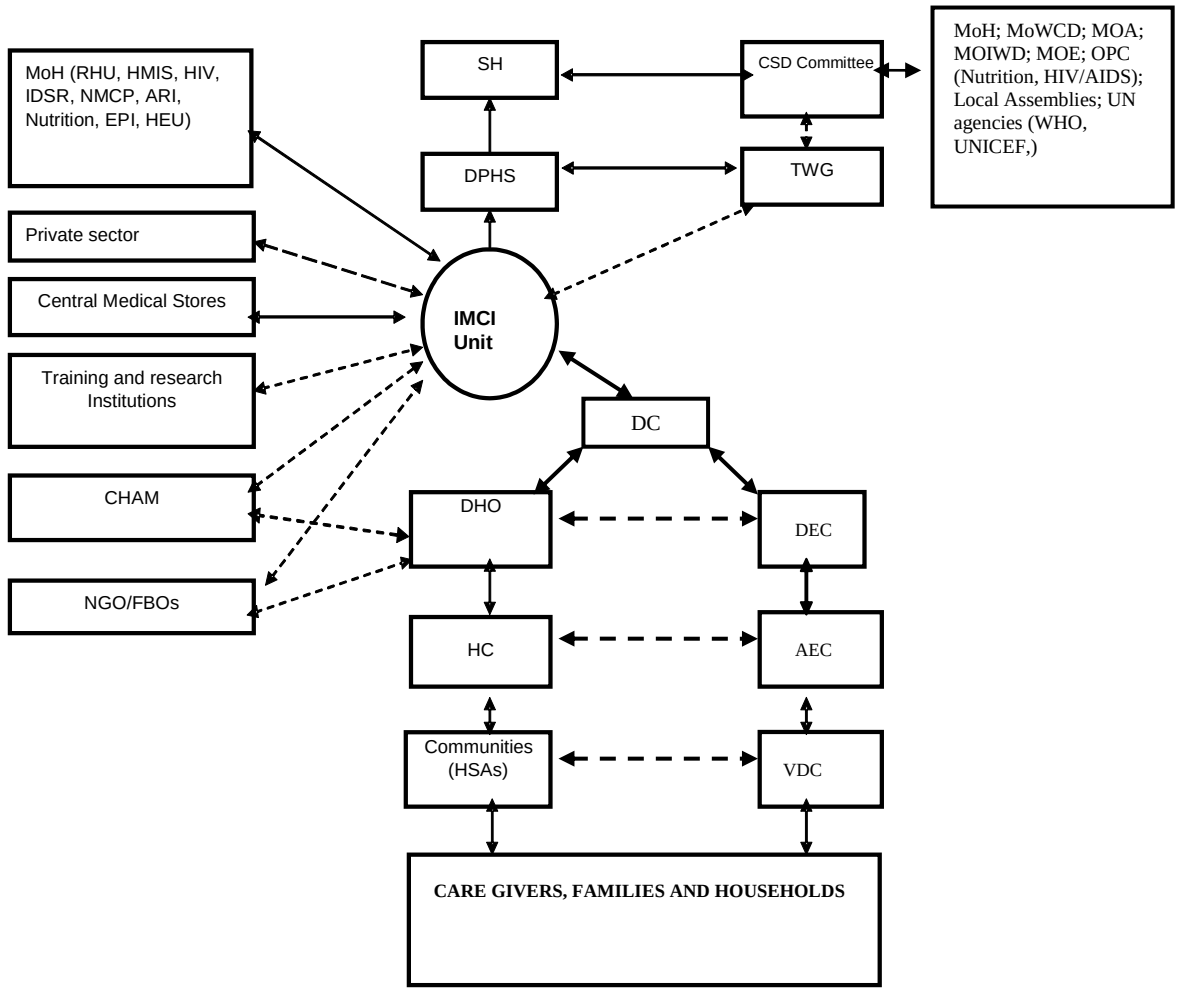
Figure 1 shows the organizational structure which illustrates the relations of the partners and how their coordination will be managed administratively and programmatically. The Ministry of Health will provide the overall leadership for IMCI in Malawi through its administrative structure from the Headquarters to the community level. This leadership role will be supported by policy and programmatic contributions from other Section/Units within the

ministry. IMCI Unit will also collaborate with CHAM, private sector, research and training institutions, and NGOs to accelerate the implementation of IMCI. The IMCI Unit will play a secretarial role in the multi-sector Child Survival and Development (CSD) Committee and Technical Working Group (TWG).

In order to ensure an effective multi-sectoral response to IMCI there shall be a CSD Committee (CSDC) made up of Principal Secretaries and senior officials from the Government Ministries and two UN agencies (UNICEF and WHO). It will be chaired by the Secretary for Health. UNICEF will be the vice-chair for CSDC. The terms of reference of CSDC shall include policy direction, mobilization of resources and managing the partnership. The CSDC shall be assisted to make programmatic and technical decisions by a CSD Technical Working Group comprised of Directors and other senior technical officials from participating partners. Apart from providing technical advice to the CSDC, the TWG will play a role of facilitating district IMCI implementation, coordination, monitoring and supervision.

Figure 1

Institutional Framework for the implementation of IMCI in Malawi



The translation of the multi-sector response to action at district and community levels shall be through the District Executive Committees (DECs), Area Development Committees (ADCs) and Village Development Committees (VDCs). The District Commissioner shall be responsible for the multi-sectoral implementation of IMCI, with a Secretariat composed of the DHO and District Social Welfare Officer for leadership and programmatic support for all the components. The DEC shall be responsible for operational decisions for IMCI

implementation in the district. The District Technical Working Group (DTWG) shall provide technical guidance and coordination for planning, implementation, monitoring and supervision, taking advantage of other existing sectoral TWGs.

The responsibility of coordinating and directing the implementation of IMCI activities at community level will rest in the VDC. Existing community structures that may play a facilitatory role in IMCI shall be determined by VDC and used to facilitate implementation of the key care practices.

7.2 Managed Partnership

Partners in the implementation of IMCI shall be bound by the following:

- Unequivocal declaration of interest and commitment to the IMCI policy, strategy and strategic plan;
- Recognition of the need and acceptance of their roles within their mandates as well as their willingness to discharge their responsibilities;
- Institutional framework and their position and relations in it;
- Shared responsibility to advocate and support other partners to discharge their accountabilities and responsibilities.

7.3 Roles and responsibilities

The IMCI policy demands a multi-sectoral approach with the roles and responsibilities that apply to all partners and those specific each partner.

7.3.1 Roles and responsibilities common to all partners

(i) Articulate their mandate and action plan for the implementation of IMCI components 1, 2 and 3, including resource mobilization.

(ii) Provide policy, programmatic and administrative guidance and support their mandate in the relevant components.

(iii) Support health promotion and education related to all the elements in the Malawi minimum package of high impact interventions.

(iv) Ensure participation in the community dialogues.

(v) Communicate the CSDC decisions to and from all levels of the partners' organizational and management structure.

7.3.2 Partner-specific roles and responsibilities

(1) The Ministry of Health

(i) Chair and provide the secretariat for CSDC and TWG.
(ii) Take a leading role in the policy formulation/review implementation, monitoring and coordination of IMCI
(iii) Procure and supply essential drugs, supplies and equipment for case management and referral.
(iv) Plan, train and deploy health workers trained in IMCI

(v) Facilitate the signing of service agreements between CHAM and District Health Offices
(vi) Ensure access for PMTCT services and availability of Anti Retro Viral Therapy for children with HIV/AIDs.

(2) Ministry of Women and Child Development

(i) Member of CSDC, TWG and multi-sectoral training, supervision, monitoring and evaluation teams
(ii) Ensure that communities are mobilized to adopt positive health behaviors that contribute to the survival growth and development of the child.
(iii) Promote parental and adult literacy
(iv) Facilitate provision of community-based emergency transport systems.
(v) Enhance community dialogue in general to facilitate understanding, utilization and adherence to treatment and counseling.
(vi) Facilitate utilization of community structures to consolidate and promote key care practices.
(vii) Maintain a data base of NGOs/FBOs/CBOs by district

(3) Ministry of Agriculture and Food Security

(i) Member of CSDC, TWG and multi-sectoral training, supervision, monitoring and evaluation teams.
(ii) Ensure that there is food security, dietary diversification, sanitation, processing, preservation, storage and utilization of nutritious foods in households.

(4) Ministry of Irrigation and Water Development

(i) Member of CSDC, TWG and multi-sectoral training, supervision, monitoring and evaluation teams
(ii) Ensure that communities are mobilized to have sanitation facilities, access to safe water and adopt safe hygiene practices

(5) Ministry of Education

(i) Member of CSDC, TWG and multi-sectoral training, supervision, monitoring and evaluation teams
(ii) Mobilize and empower the children in schools to adopt positive health behaviors.

(6) Office of the President and Cabinet – Department of Nutrition, HIV and AIDS

(i) Member of CSDC, TWG and multi-sectoral training, supervision, monitoring and evaluation teams
(ii) Coordinate multi-sectoral nutrition program at national level and ensure consistency, adequacy and relevance across sectors.
(iii) Promote food security, dietary diversification, sanitation, processing, preservation, storage and utilization of nutritious foods in households and communities in relation to the minimum package of high impact interventions.

(7) Local Assemblies

(i) Provide leadership in the making of operational decisions for the implementation of IMCI at district level.
(ii) Ensure equitable resource allocation and holistic implementation of IMCI throughout the district in line with the national policy direction and guidelines.
(iii) Monitor progress of IMCI implementation with respect to the mandates of the various government ministries and partners.
(iv) Work with ADCs and VDCs to ensure their functionality and support to IMCI.

(8) CHAM

(i) Member of TWG and multi-sectoral training, supervision, monitoring and evaluation teams.
(ii) Speed up the signing of service agreements with the District Health Offices
(iii) Ensure that the pre-service training curriculum contains components of IMCI.
(iv) Ensure access for PMTCT services and availability of Anti Retro Viral Therapy for children with HIV/AIDs.
(v)

(9) NGOs /FBOs /CBOs

(i) Represented in the CSDC and TWG by the parent government ministry/department
(ii) Identify partners to implement the Malawi minimum IMCI package.
(iii) Ensure that their interventions are approved and supported by their parent government ministry.
(iv) Provide technical support for monitoring and evaluation and district and lower levels.
(v) Ensure sustainability of initiatives beyond the period of donor support.

(10) United Nations Agencies

UNICEF:
(i) Vice-chair for CSDC
(ii) Member of TWG and multi-sectoral training, supervision, monitoring and evaluation teams.
(iii) Resource mobilization
(iv) Programmatic and technical support to the Government of Malawi
(v) Procurement and supply services including procurement services for all Anti-retrovirals ARV) in Malawi
(vi) Support surveys, operations research and evaluations related to IMCI and pediatric care.
(vii) Support establishment of Pediatric Anti-retroviral therapy sites
(viii) Advocacy to prioritize ARV treatment for children and women.

WHO

(i) Member of CSDC, TWG and multi-sectoral training, supervision, monitoring and evaluation teams.
(ii) Resource mobilization.
(iii) Programmatic and technical support to the Ministry of Health.
(iv) Support surveys, operations research and evaluations related to IMCI.

FAO

(i) Member of TWG and multi-sectoral training, supervision, monitoring and evaluation teams.
(ii) Resource mobilization.
(iii) Programmatic and technical support to the Ministry of Agriculture.

WFP

(i) Member TWG and multi-sectoral training, supervision, monitoring and evaluation teams.
(ii) Resource mobilization.
(iii) Provide food to most vulnerable groups and communities.

(11) Bilateral agencies and other donor partners

(i) Represented in the TWG.
(ii) Resource mobilization to scale up IMCI to reach universal coverage of high impact interventions.
(iii) Ensure that the three components are supported concurrently.

7.4 Communication

The following constitute the key tenets in the comprehensive communication strategy for child survival, growth and development:

- Community dialogue in general shall be used as a basis for community mobilization and for promoting community participation and ownership.
- Partners shall ensure that no demand is created at the community level without the commensurate and timely availability of goods and services.
- Institutionalization at community level to ensure sustainability and to take cognizance of the need for long-term effort for the appropriate practice to be achieved.

7.5 Resource mobilization

This policy envisions a situation where all the three components of IMCI are implemented in an accelerated manner to achieve universal coverage of high impact interventions within the shortest time possible. This demands mobilization and commitment of significant and sustained financial resources. The main framework for resource mobilization shall be:

- CSDC where both government and donor partners demonstrate their commitment to release additional funds;
- Transparent and accountable articulation of the needs that can easily attract funding;
- Efficient allocation and utilization of resources and the achievement of results as the main driving force for mobilization of additional resource;
- Partners accessing resources in global initiatives through national, regional and global consortiums.

7.6 Monitoring and evaluation

The focus of monitoring and evaluation (M&E) will be on the situation of survival, growth and development of children; inputs, process, outcomes and impact of the accelerated high impact interventions; and the effectiveness of all the arrangements, mechanisms and procedures put in place to realize the vision, mission, goal and objectives of this policy. Community participation, decentralized decision making, transparency and accountability will receive special attention. Participatory methods should be used in the collection, analysis and interpretation of data and information. M&E should take advantage of and be clearly linked to existing M&E frameworks and systems to minimize duplications and confusion of communities.

7.7 Policy review

This policy shall be reviewed periodically, at least every 5 years, to incorporate emerging issues emanating from changing situation, effects of intervention, other policy reviews, research findings and lessons learnt as and when they arise. The main criteria shall include:

- Relevance to the situation of children with regard to survival, growth and development and the changing local context and setting.
- Adequacy in dealing with coverage of interventions, partnerships, communication and resource mobilization.
- Effectiveness and efficiency of implementation as perceived by implementers, donors and recipients of the IMCI goods and services.
- Acceptance and satisfaction of all the stakeholders with the policy and all the documents emanating from it;

Annex 1

The Seventeen Key Care Practices in Malawi

1. Exclusive breastfeeding
2. Complementary feeding and sustained breastfeeding
3. Micronutrients
4. Mental and social development
5. Orphan care and other vulnerable children
6. Hygiene and sanitation
7. Malaria prevention
8. Child abuse and neglect
9. HIV/AIDS prevention and care
10. Feeding and giving fluids during illness
11. Home health practices
12. Accidents and injuries
13. Immunization
14. Health care seeking
15. Compliance treatment, follow up and referral
16. Care for pregnant women and lactating mothers
17. Men's participation in child care

Annex 2

The Minimum Package of High Impact Interventions for Accelerated Child Survival, Growth and Development in Malawi

High impact interventions	Operational definitions
For prevention	
1. Insecticide-treated bed nets (ITNs)	• Protecting all children under-five years of age and pregnant women from malaria by ensuring that they regularly sleep under recommended insecticide-treated mosquito nets (ITNs). • Caregivers acquire insecticide-treated mosquito nets • Caregivers re-treat the ITNs at least once a year
2. Intermittent presumptive treatment (IPT) of malaria in pregnancy	• Administering at least two doses of recommended anti-malarial (SP), one month apart, for the prevention of malaria during pregnancy, starting from the second trimester (after quickening)
3. Breastfeeding,	• Breastfeed infants exclusively for six months, taking into account policies and recommendations on HIV and infant feeding • Infants of less than 6 months of age who were exclusively breastfed in the last 24 hours
4. Complementary feeding;	• Starting at six months, feed children freshly prepared energy- and nutrient-rich complementary foods, while continuing to breastfeed up to two years or more. • children aged 6-9 months receiving breastfeeding and appropriate complementary foods and children who are 24 months of age or under and are still being breastfed
5. Immunization;	• Take children as scheduled to complete a full course of immunizations (BCG, diphtheria-pertussis-tetanus (DPT), oral polio vaccine (OPV) and measles) before their first birthday. • children aged 12-23 months vaccinated against measles before 12 months of age • children aged 12-23 months who are fully immunized against diphtheria, pertussis and tetanus before their 1st birthday
6. Antenatal care and clean delivery;	• Ensure that every pregnant woman receives the recommended four antenatal visits and recommended doses of tetanus toxoid (TT3) vaccination, and is fully supported by her family and community in seeking appropriate care, especially at the time of delivery and during the postpartum/lactation period. • Pregnant women receive institutional delivery or delivered by skilled attendants. Use of simple and clean delivery kits (plastic sheet, thread to tie the umbilical cord, new razor blade to cut the cord, umbilical cord cutting board, and a small bar of soap to wash hands).
7. Vitamin A	• Provide children with adequate amounts of micronutrients (particularly Vitamin A, iodine and iron), either in their diet or through supplementary sources. • Children aged 6-59 months who have received a high dose of Vitamin A in the last 6 months
8. Water and sanitation	• Dispose of all faeces safely, and wash your hands with soap after defecation, and before preparing meals and feeding children
For treatment	
9. Oral re-hydration therapy (ORT);	• Continue to feed and offer more fluids, including breast milk, to children when they are sick. • Children under 5 with diarrhoea in the last 14 days given ORT • Sick children whose caregivers are advised to give extra fluid and continue feeding
10. Anti-malarial (treatment with SP);	• Children who were reported to have had fever in the previous 2 weeks and were treated with locally recommended anti-malarial treatments • Caregivers of children who know at least two of the following signs

High impact interventions	Operational definitions
	for seeking immediate medical care – child not able to drink or breastfeed; child becomes sicker despite home care; child develops a fever (in malaria-risk areas or if child aged less than 2 months); child has fast or difficult breathing; child has blood in the stools; child is drinking poorly – divided by the total no. of caregivers • Proportion of children prescribed oral anti-malarial, whose caregivers can correctly describe how to give the proper treatment
11. HIV and AIDS &Pediatric ART	• Children with suspected or confirmed HIV infection. The clinical expression of HIV in children is highly variable. Some HIV positive children develop severe HIV-related signs and symptoms in the first year of life. Other HIV positive children may remain asymptomatic or mildly symptomatic. • The management of the child with confirmed HIV infection, suspected HIV or possible HIV includes antiretroviral drug treatment and cotrimoxazole therapy. • ART is not a cure; the goal of ART is to prolong life by disabling the virus in the individual. ARV doses given to PMTCT babies and PMTCT mothers. Adherence to treatment is therefore important. • Cotrimoxazole Preventive therapy is given to children with confirmed or suspected HIV infection or children who are HIV exposed to prevent *pneumocystis carinii pneumoniae* (PCP) and other opportunistic infections. • Cotrimoxazole preventive therapy should be given from 6 weeks of age until child has been tested and HIV infection ruled out. If an HIV exposed infant is confirmed HIV positive, cotrimoxazole preventive therapy should be continued indefinitely
12. Antibiotics for sepsis, pneumonia and dysentery;	• Access to the recommended antibiotics and administration by HSAs or authorized caregivers for newborns with sepsis, children with pneumonia or fast breathing and children with mucoid or blood-stained stools. • Recognize when sick children need treatment outside the home and take them for health care to the appropriate providers.
13. De-worming	• Children aged 6-59 months who have received a dose of anti-helminths drug (albendazole) in the last 6 months • Pregnant women who have received a dose of anti-helminths drug (albendazole) during pregnancy
For social and mental development	
14. Child protection	• Prevent child abuse/neglect and take appropriate action whenever it occurs. • Four forms of child abuse and/or neglect: physical, sexual, emotional and neglect (denying a child food, cleanliness, education, prompt treatment, etc), • Proportion of caregivers who can identify the four forms of abuse and/or neglect and their related signs and symptoms • Proportion of caregivers who have witnessed child abuse and/or neglect and have taken action to stop it
15. Early Learning and Stimulation	• Promote mental and social development by responding to a child's needs for care, and through talking, playing and providing a stimulating environment. • Caregivers who promoted stimulation of the child through talking, playing, and other appropriate physical and emotional interactions appropriate for the age in the last three days.

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