

FIGURE 2: HOW CHALLENGES TO SCALE UP IMCI HAVE BEEN ADDRESSED

- **Challenge: Strategic differences with regards to the role of IMCI / possible impact of IMCI:**
 - Through state planning meetings and the release of operational guidelines for IMCI implementation (India)
 - The 2007-2009 medium-term expenditure framework has a budget line for child health and IMCI (Nigeria)
 - Increasing advocacy for IMCI – planning to develop a child health policy (Kenya)
 - A strategy for Maternal, Neonatal and Child Health has been developed and this recognises IMCI as one of the delivery vehicles for scaling up MCNH interventions (Nigeria). It is hoped that this strategy would facilitate the availability of and access to funds for IMCI
 - A monitoring and evaluation centre for child health has been developed, and a person appointed to monitor and evaluate IMCI (Moldova)
 - One person has been assigned to oversee the IMCI team at national level (Eritrea)
 - Sensitisation visits to district coordinators have been conducted at the beginning of the year prior to the development of the district programme of action (Eritrea). Planning with districts also occurs in Kenya
 - A national training strategy was developed, in consultation with national and international partners (Kazakhstan)
- **Financial challenges: Re-distribution of funds / lobbying for more funds:**
 - Other sources of funding have been utilised for supporting IMCI case management courses and supervision (Eritrea)
 - Funds for IMCI have been taken from central government and training conducted at district level (Indonesia)
 - Negotiations with donor organisations / other stakeholders are being held (Uzbekistan, Ghana)
- **Lack of resources for IMCI implementation, especially lack of accommodation, time, training materials and human resources:**
 - Non-residential courses have been held where possible (Kenya)
 - IMCI courses have been decentralised (Eritrea)
 - Districts have been provided with a set of training materials to make them self-sufficient
 - Exercises have been separated from the modules - modules are not taken home by participants and are thus re-used. This reduces the cost of printing modules, and is unlikely to affect quality (Uganda)
 - Attempts have been made to shorten the duration of training to reduce cost (5-8 days): 5-days in China, Fiji, Indonesia, Kazakhstan, Nicaragua, Nigeria, Madagascar, Peru and Sudan; 6-days in Ethiopia, India, Indonesia, Kazakhstan, Madagascar, Nigeria, Niger and Uganda; 7-days in China, Egypt, Jordan, Nepal and Peru; 8-days in Egypt, India, Jordan and Kosovo
 - Trained health workers organise on the job training for untrained health workers (Uzbekistan)
 - An abridged course for senior managers has been developed (Kenya, Ghana, Indonesia, Nicaragua and Madagascar)
 - Computer-based training (6-days) has been developed (Kenya)
 - District-based facilitators and clinical instructors have been trained (Uganda)
 - Pre-service IMCI training has been expanded (India, Uzbekistan, Kazakhstan, Cambodia, Moldova)
- **Poor reading ability of health workers:**
 - A 6-day abridged course and a simplified 5-day course have been developed – the 5-day course has little reading as health workers at operational level had difficulty reading (Nigeria)
 - The duration of the course has been prolonged for health workers who have difficulty reading (Vietnam)