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Maternal and Child Survival Program

The Global Evidence on Health Systems in IMCI and iCCM contexts

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A note on evidence …

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- And if they show you a high-quality systematic review that proves their point, ask them: where is the evidence on cost-effectiveness?
- If they cannot show you both, be suspicious!

A note on ‘health-nutrition’ integration

- Health-nutrition integration is bigger than ensuring specific nutrition interventions are included in specific health settings – **it is about nutrition being treated as an inextricable part of health across the health system**!

What you’ll be part of this week

- Global and country experts discussing evidence-based nutrition interventions for ill and vulnerable newborns and children, and their ‘real-world’ experiences of implementation

What you'll hear from me

- Findings from the BMJ Strategic Review of 20 years IMCI and iCCM – to root our discussions on this week in the broader context of health systems – for both MoH staff and development partners!

Methodology

- Qualitative and quantitative review
- Over 1,500 publications and hundreds of expert opinions from nearly 100 countries
- Strategic review published by WHO in 2016
- Expanded series published by BMJ in 2018
- I am not an author!!

“Child health strategies must be reappraised to account for changing epidemiology, new knowledge about causes and effective service delivery, and advances in diagnostic and other technologies”

"The management of sick newborns at all levels [needs more emphasis]."

"The most commonly mentioned barriers must be foremost in the minds of our thinking on and redesigning the future of child health and development."

Theme 1: Significant health workforce challenges

- Despite significant investment in training, this has been less effective than originally hoped: one-third of ill children are still not receiving appropriate treatment
- Causes include: inadequate training budgets; staff turnover, retention, and motivation issues; weak mentorship and supervisory systems; and insufficient facility readiness (drugs, commodities, and equipment)

Theme 1: Significant health workforce challenges

The major barriers to implementing IMCI at **national** level were:

- Budget for training (85%)
- Mentorship and supervision (74%)
- Cost or sustainability of activities (63%)
- Availability of a dedicated budget line (60%)

Theme 1: Significant health workforce challenges

The major barriers to implementing IMCI at **district** level were:

- Staff turnover (84%)
- Budget for training (82%)
- Mentorship and supervision (74%)

Theme 1: Significant health workforce challenges

The major barriers to implementing IMCI at **facility** level were:

- Staff retention (80%)
- Mentorship and supervision (79%)
- Staff motivation (74%)

Theme 1: Significant health workforce challenges

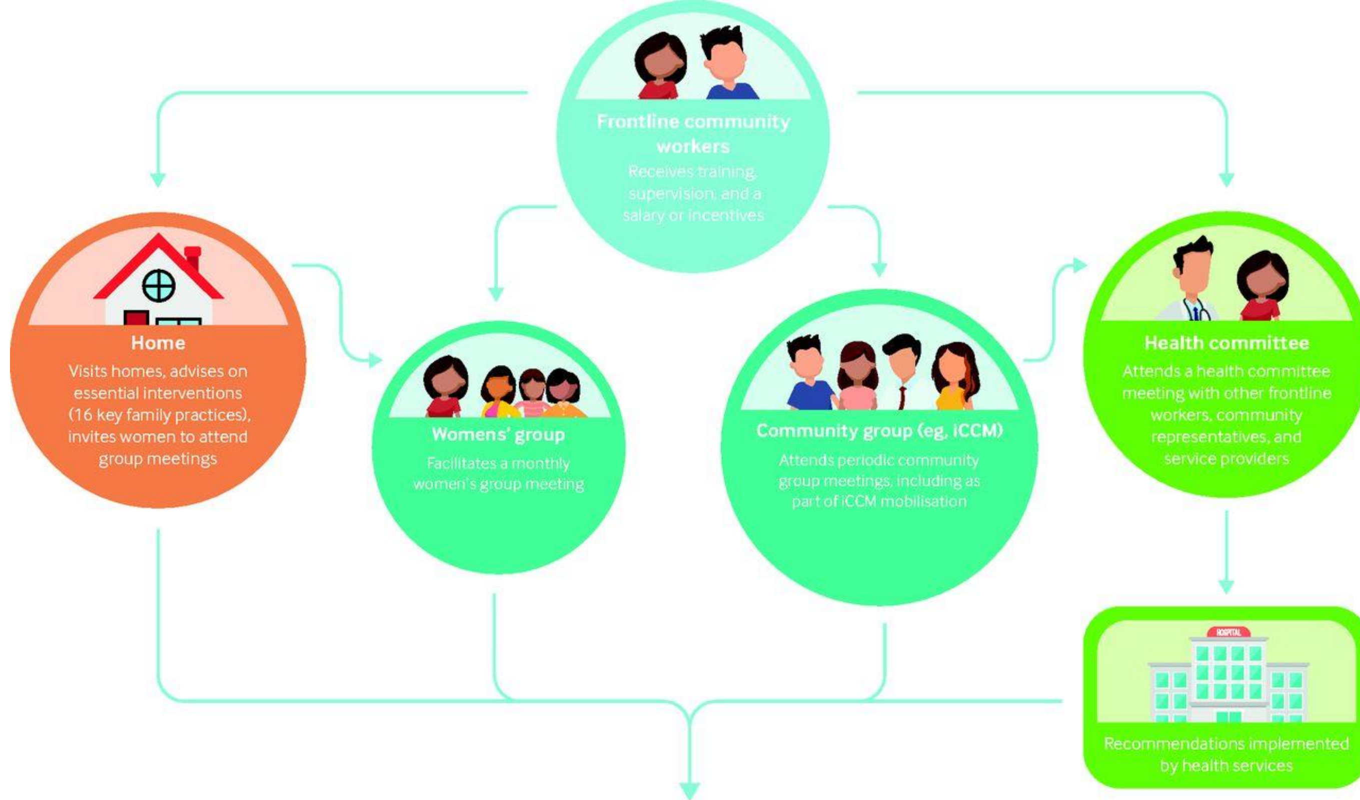
- Training alone has limited benefits in improving quality – it has to be combined with other components such as supervision and group problem solving
- The effect of different approaches varied from -16% to +55% change in performance – demonstrating the difficulty in predicting what will work in each context
- This shows the importance of iterative approaches

Theme 2: Community involvement remains weak

- The 'community' thread of IMCI remains the most weakly implemented, e.g. 'continue to feed and offer more fluids, including breast-milk, to sick children' advice is not given to families
- This is due to lack of clarity on best approaches; lack of investment in CHWs; and donor-funded initiatives isolated from the broader system / referral mechanism

Theme 2: Community involvement remains weak

"At country level, implementation of IMCI has focused mainly on the first component (improving health worker skills) to the exclusion of strengthening health systems and community engagement. This, to a large extent, is due to overemphasis on the former by WHO, UNICEF and implementing and funding partners."

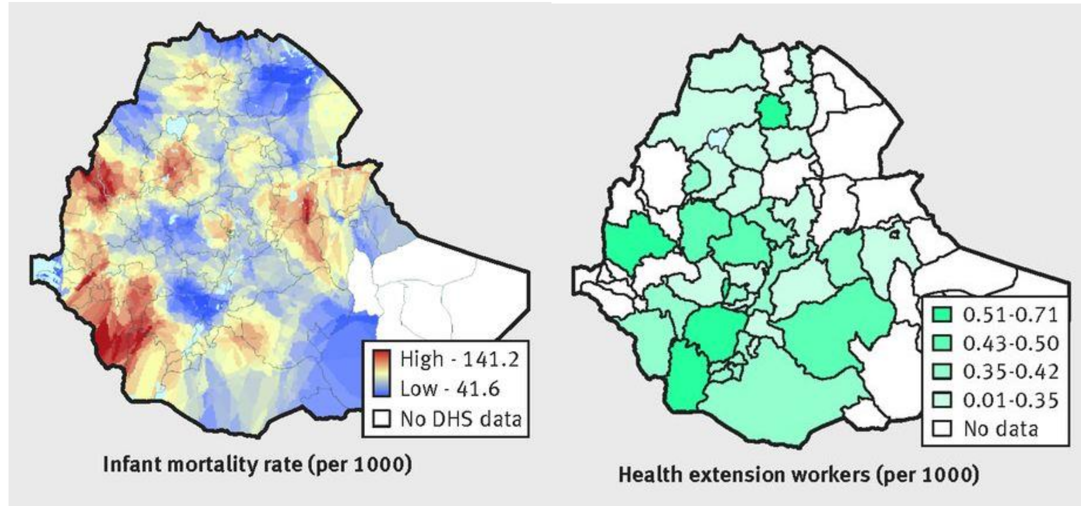


Frontline community workers
Receives training, supervision, and a salary or incentives
Home
Visits homes, advises on essential interventions (16 key family practices), invites women to attend group meetings
Womens' group
Facilitates a monthly women's group meeting
Community group (eg, iCCM)
Attends periodic community group meetings, including as part of iCCM mobilisation
Health committee
Attends a health committee meeting with other frontline workers, community representatives, and service providers
HOSPITAL
Recommendations implemented by health services
Capabilities are strengthened
Individual
Members of the household and the community can live a healthy lifestyle, discuss and promote healthy action, and respond to needs
Household
Household members can rely on family/husband/partner support to make healthy decisions and together respond to needs
Community
Communities can take action and collaborate with others engaged in health, education, and development
Health services
Health management and workforce can join with communities and other stakeholders to create more responsive services and programmes in health and development

Theme 3: Stark inequities in coverage

- Both IMCI and iCCM appear to have facilitated reductions in inequities in care – but not by enough
- This is due to: lack of inter-sectoral action and ongoing medical focus; systems strengthening in already strong areas compounding inequities; failure of coordination by partners, globally and in-country; and inadequate sustainable financing

Theme 3: Stark inequities in coverage



Theme 4: M&E systems are highly fragmented

- Integration of health services has historically neglected M&E systems, with negative consequences for health workers and service delivery
- This is due to: multiple vertical programmes being funded, governed, and managed separately; lack of resources for integration; and low priority afforded to information systems at national level

Theme 4: M&E systems are highly fragmented

- "… [HCWs] report multiple programmes using multiple forms. This can be cumbersome, duplicative, time consuming, and lead to poor quality of data"
- " … leads to game playing and data tampering"
- "Workers don't have time to input the data and nobody trusts the data, so nobody uses them and, in turn, healthcare workers care even less about the data"

Theme 5: DHMTs are not adequately resourced

- DHMTs have many initiatives thrust onto them without adequate capacity or authority to carry out their duties
- Repeated intrusion of new vertical programmes can be disruptive and compete for time and attention rather than supporting an integrated delivery platform
- Consequences include: coordination challenges; drug-stock-outs; delayed repairs; and HCW absenteeism

Bringing it together: a health systems lens is key

- Health systems issues were critical to limiting implementation of IMCI and iCCM
- The biggest challenges highlighted were: staff quality, quantity and turnover; lack of supportive supervision; lack of essential equipment and consumables; and robust monitoring systems

Bringing it together: a health systems lens is key

- Beyond this, four critical factors stood out for successful IMCI programming:
  - Strong central leadership
  - Commitment to strengthening health systems;
  - Clear vision and focus on integration between primary and community levels of care; and
  - Strong pre-existing community networks

"A recent Cochrane review found the [IMCI] was associated with a **15% reduction in child mortality** when activities were implemented in health facilities and communities."

"High-implementer countries (≥90% of districts) with all three IMCI components in place were **3.6 times more likely to achieve MDG-4** than other countries."

"Problems identified by the multi-country evaluation of IMCI 10 years ago—"difficulties in expanding the strategy at national level while maintaining adequate intervention quality," and failure to account for the "full weight of health systems inadequacies,"—remain today"

Conclusions

- Interventions are not implemented in a vacuum – they are implemented in the context of a broader health system
- It is critical to keep this broader system in mind over the coming days as we dive into the interventions
- Remember: integration has to be rooted in the health system, not just at service delivery level

Bonus section: beyond health systems to societies

- Global evidence shows that children's growth deteriorates rapidly during and after illness if feeding practices do not meet the additional nutrient requirements
- There are a number of global guidelines to this effect, but implementation of these is incomplete
- A systematic review* from South Asia asks why …

* Paintal K and Aguayo VM. 'Feeding practices for infants and young children during and after common illness. Evidence from South Asia. *Maternal and Child Nutrition* (2016), 12 (Suppl 1), pp39-71

Bonus section: beyond health systems to societies

- When sick, most children are breastfed, but few are breastfed more frequently as recommended
- Restriction / withdrawal of complementary foods during illness is frequent due to: lack of appetite (real or perceived); traditional beliefs and behaviours; and / or sub-optimal counselling by health workers

Bonus section: beyond health systems to societies

- Many care-givers seek support on feeding from health care providers but receive little or no advice
- Care-givers often turn to elders and traditional practitioners – with traditional beliefs guiding the use of 'special' feeding practices contrary to guidelines
- There is in urgent need for care-givers to receive evidence-based guidance in this area

Bonus section: beyond health systems to societies

- Reasons for reducing breast-feeding:
  - “Infants can’t digest breast-milk when sick”
  - “Child has no appetite”
  - “Breast-milk has become harmful due to mystical forces / illness transmitted to child through breast-milk”

Bonus section: beyond health systems to societies

- Reasons for fluid restriction:
  - "Fluids cannot be absorbed during diarrhoea and are therefore harmful"
  - "Reduction in stool volume in children shows an improvement in child's condition"

Bonus section: beyond health systems to societies

- Reasons for restricting food intake:
  - "Child has less appetite"
  - "Unable to feed child more [in line with guidance] due to resources or time constraints"
  - "Illness has disturbed the digestive system and 'normal foods' would put stress on child's stomach / trigger diarrhoea"
  - "Withholding certain foods will help to cure diarrhoea / prevent 'big belly'"

Bonus section: beyond health systems to societies

- Advice from health workers:
  - Most gave little or no advice on how to feed during or after illness
  - Advice typically included to continue breastfeeding / ORS, though some advised withholding breast-milk
  - No studies reported advice to encourage sick children to each soft, varied, and favourite foods during illness as recommended by WHO

Bonus section: beyond health systems to societies

- Advice from family elders:
  - "Opt for home remedies as first line of treatment"
  - "Accept children's refusal to eat & delay feeding by 1 day"
  - "Refrain from giving sick children certain foods such as fish, meat, vegetables, or milk"

Bonus section: beyond health systems to societies

- Effective solutions (in South Asia) included behaviour change communication – home visits and group counselling by trained CHWs – and cooking demonstrations and interpersonal counselling sessions on mothers' IYCF practices
- These are highly context specific

(Final) Conclusions

- Interventions are not implemented in a vacuum – they are implemented in the context of a broader health system **<u>and</u>** the broader society
- It is critical to keep both of these in mind over the coming days as we dive into the interventions

For more information, please visit **www.mcsprogram.org**

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Improving Nutrition Services in the Care of the Ill and Vulnerable Newborn and Child Workshop
30 October–2 November 2018
Accra, Ghana
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