



DEPARTMENT OF HEALTH

INTERGRATED MANAGEMENT
OF CHILDHOOD ILLNESSES
POLICY 2014





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ANNEX FIVE: IMCI TECHNICAL WORKING COMMITTEE

a. Terms of Reference for the Working Group

Common childhood disease including pneumonia, diarrhoea, measles, tuberculosis and malnutrition are the major causes of morbidity and mortality in children in Papua New Guinea. Despite the best efforts on EPI and other child health intervention so far the trend had remained same or worsened over past decade.

The World Health Organisation and UNICEF developed an "Integrated Management of Childhood Illness" (IMCI) to address the increasing problem of children of developing countries and at the same time address consequence of poverty. This approach emphasizes that action should be taken on three essential components of improving and developing health workers skills, improving health systems and initiating appropriate family and community practices. Some countries of the region have started incorporating it into their child health programs.

Several Paediatricians and senior staff of the department of health had the opportunity to participate in various inter-country training programmes on aspects of IMCI. A briefing session with senior staff of the Ministry, medical school and funding partners was held on February, 2000.

The recommendation of the meeting was to establish a national level working group consisting of clinicians, department of health staff and partner agencies. The objective of the working group is to advice the department of health on IMCI strategies available that will reverse the increasing trends of under-five morbidity and mortality.

b. Members of the Working Group

1. Director Health Improvement Branch
2. Principal Advisor Family health
3. SMO Child Health
4. Nutritionist Family Health
5. SMO Malaria Control
6. Chairperson Paediatric Society
7. Chief Paediatrics
8. Professor of Paediatrics at UPNG
9. Representative from Provincial Health
10. Representative from UNICEF
11. representative of WHO
12. Representative of WCHP
13. Any other co-opted

c. Secretariat

The Department of Health and in particular the Child Health Section will provide secretariat service for the working group.

¹Exploring Concepts of Gender and Health. Ottawa: Health Canada, 2003 <http://www.hc-sc.gc.ca/english/women/exploringconcepts.htm>

ANNEX FOUR:

AIP	Annual Implementation Plan
AIDS	Acquired Immunodeficiency Syndrome
CAP	Community Action Participation
CHP	Community Health Post
CHW	Community Health Worker
CRC	Convention on the Rights of the Child
DHS	Demographic Health Survey
EPI	Expanded Program Of Immunization
FHS	Family Health Services
FBO	Faith-based Organization
HFS	Health Facility Survey
HHS	Household Survey
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IMCI	Integrated Management Of Childhood Illness
LLG	Local level Government
MCH	Maternal Child Health
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
NDoH	National Department of Health
NGO	Non-government Organization
NHIS	National Health Information System
PNG	Papua New Guinea
PNGIMR	Papua New Guinea Institute of Medical Research
TACH	Technical Advisor Child Health
TWG	Technical Working Group
UN	United Nations
UNICEF	United Nations Children's Fund
VAW	Violence Against Women
VCT	Voluntary Counseling and Testing
VHV	Village Health Volunteer
WHO	World Health Organization

FOREWORD



The health care system has suffered over decades due to many factors with lack of clear policy direction being one of them.

Performance indicators of child health status showed slow improvement in the last 3 decades. This is going to change with implementation of the Integrated Management of Childhood Illness Policy.

Integrated Management of Childhood Illness (IMCI) is a strategy promoted by the World Health Organisation, to reduce mortality of children under 5 years and promote their healthy growth and development. It targets the most commonest childhood illnesses and consists of three components focusing on community, health system and skills of health workers. It utilizes exceptional innovative approaches to reduce high disease burden and mortality by strengthening primary health care.

It is important to note that the Integrated Management of Childhood Illness developed and promoted by the World Health Organization is not a new concept for Papua New Guinea. More than 10 years before launching of IMCI strategy, the doctors from Papua New Guinea recognized the importance of integrated assessment of sick child and developed 10 steps check list for ALL sick children. Similar approach became later a standard of management of child illnesses around the globe that proves high qualifications, creativity and potential of health professionals in Papua New Guinea.

The Policy puts basis for implementation of all components of the IMCI strategy in a sustainable way through coordination, leadership and accountability of the Government of Papua New Guinea for the health of children. IMCI will also address early recognition and treatment of diseases at the community level, including referrals.

The implementation of the Policy will lead to significant improvement of the quality of care for children especially at primary health facilities and in communities. It also creates a framework for partnership with NGOs and development partners towards better access and quality of integrated child health services.

The Policy expresses the commitment of the Government of Papua New Guinea to improve the quality of life of our children. I declare and commend this IMCI policy as a priority approach to address health needs of children of Papua New Guinea.



Hon. Michael Malabag.
Minister for Health

ACKNOWLEDGEMENT



The publication of the Intergrated Management of Childhood Illness Policy marks a new era for the Department of Health in its ongoing efforts to deliver quality integrated child health care services to sick children at out-patient settings and in rural communities of Papua New Guinea.

The policy allows for better implementation of child health programs in a more integrated and systematic way, improve coordination between stakeholders in implementation of health priorities and strengthens the position of the Government as a Leader of health agenda in Papua New Guinea.

The National Department of Health expresses its gratitude to all those who contributed to devopment and adaptation of this Intergrated Management of Childhood Illness Strategy to fit health situation of Papua New Guinea

I acknowledge the Family Health Branch for setting IMCI standards and Policy Unit for their assistance and guidance during the process of development of this Policy. My words of appreciation and gratitude are also directed to PNG Paediatric Society as well as Medical Standards, Health Promotion, Disease Control Branch and other Units of National Department of Health for their time and consultative contributions to the development of this document. Last but not the least are the Development Partners such as World Health Organisation who assisted the Government in all steps of development of the IMCI Policy.

I look forward with you all to the successful implementation of the National Policy on Integrated Management of Childhood Illness in Papua New Guinea as the way for significant improvement of quality of health care delivered to sick children and better access to child survival interventions. Allowing a child to grow healthy is our responsibility and we have to fulfil our obligations towards children as agreed and declared in the National Health Plan.



Mr Pascoe Kase
Secretary for Health

	acquired identity that is learned, changes over time, and varies widely within and across cultures. Gender is relational and refers not simply to women or men but to the relationship between them ¹ .
Care takers	Parent, relatives or other people who looks after or takes care of a child with responsibility for making sure that a child is living healthy.
Care givers / Care providers	Person who helps in identifying or preventing or treating illness or disease
Care-seeking Behaviour	Actions relating in seeking treatment/cure for a health problem in children
Under 5 Mortality Rate	Proportion of child deaths (0-5years) per 1000 live births
Cost Effective	Form of analysis that compares the relative costs and favourable outcomes of two or more courses of action or cheap for value of product; means priced right for what it's worth.
Exclusive Breastfeeding for first 6 months	Infant receives no other liquids or solids, not even water other than breast milk in the first six months of life
Hypothermia	Condition in which core temperature drops below the required temperature for normal metabolism and body functions which is defined as temperature less than 36.5° C
Hypoglycemia	A medical emergency that involves an abnormally low level of glucose in the blood, measured to be less than 2.2mmol/L
Immunisation	Process by which an individual's immune system is made stronger to help protect them against certain infectious diseases
Low Birth Weight	Defined as a birth weight of an infant born alive of less than 2.5kg regardless of gestational age
Malnutrition	Is the condition that results from eating a diet in which certain nutrients are lacking, in excess (too high an intake), or in the wrong proportions
Nutrition	The processes by which an organism assimilates food and uses it for growth and maintenance
Prematurity	Babies born before 37 completed weeks of gestation
Stunting	Stunting growth refers to low height-for-age when a child is short for his/her age.
Underweight	Moderate and severe – below minus two standard deviations Underweight children are more likely to suffer from impaired development and are more vulnerable to disease and illness. Carries long term developmental risks.
Wasted	Wasted refers to low-weight- for height (-2 Z score WHO) where a child is thin for his/her height but not necessarily short. Also known as acute malnutrition, this carries an immediate increased risk of morbidity and mortality.
Quality of care at referral level	This refers to the quality of care at the facility which is receiving the patient

ANNEX THREE: GLOSSARY

Advocacy:	A combination of individuals and community actions that gets political attention to meet a socialist obligation for favourable health outcome (WHO, 1992)
Communication Channels:	Mode by which communication on specific health issues is disseminated to health workers, families and individuals and in setting such as workshops, meetings and to social gathering of a mix of people.
Child Health:	A section of Family Health program that deals with health of children below 18 years and in Papua New Guinea mainly 12 years and below.
Community:	A group comprising of a number of people or individuals sharing one geographical boundary, culture, religion or other grouping for the nature of relationships of support to one and other.
Community based Organizations:	Formal, non-government organizations existing in the community that help promote and implement community based interventions
Community IMCI:	The third strategy of Integrated Management of Childhood Illnesses (IMCI), that deals with community improvement activities to support child survival.
Community based interventions	Preventive and promoted activities undertaken at the community level
IMCI:	Integrated Management of Childhood Illnesses has three main components; training of health workers, system support through drugs and equipment and community preventative programs.
IMCI Policy:	Health Department statement or procedure which defines the parameters for IMCI implementation in PNG in response to high under five mortality rate and available resources.
Health:	A state of complete physical, social, mental and spiritual wellbeing. Not merely absence of diseases or infirmity (WHO constitution, 1948).
Health Education:	Education on Health issues which is an opportunity for obtaining new knowledge and skills to improve lives of children in families and individuals in the community.
Health Improvement:	Working towards the national vision of a nation of healthy individuals and children free from diseases and infirmity.
Healthy Islands:	The PNG government is committed to and involved in activities that involve better quality of life for its people and children.
Healthy Islands setting:	The setting that is based on Healthy Islands programs and activities such as provision of clean water and adequate sanitary practices for the village and the community.
IEC:	Information, Education and Communication
Intersect oral Collaboration:	Recognised relationships between parts of different sectors that exist in a community aiming at improving health outcomes for that community.
Interventions:	A list of identified specific activities that are shown by World Health Organisation to reduce under five mortality. These interventions are most importantly In-service Training for Health Workers and Pre-services Training for undergraduate's students. The others are administration of antibiotics for Pneumonia and Antimalarial for malaria cases. The rest are exclusive breastfeeding up to 6 months of age, Complementary Feeding, Immunization, Sleeping inside Treated Bed Net in the night, Mass Administration of Vitamin A, Supply of Oral Dehydration Salts (ORS) during gastroenteritis outbreak, Zinc administration and Deworming activities.
Non-Government Organization:	Formal organisation that exists in the country that have formal association with the government system in delivery of health services.
Policy:	Guidelines for coordinated action across institutional settings. It can be formal as in legislation, or informal as in agreement.
Public Health:	The science of promoting health to the public using promotion and prevention strategies and prolong life through organized methods of the society.
Village Health Volunteers:	This name encompasses the roles of all health workers outside the formal sector and includes village birth attendants, community based distributors, marasin meri, village health promoter, village health educator or other. In essence they are volunteers selected by the community to support the families in child survival related health issues.
Gender	Gender refers to the array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the sexes on a differential basis. Whereas biological sex is determined by genetic and anatomical characteristics, gender is an

EXECUTIVE SUMMARY

Integrated Management of Childhood Illnesses Policy developed by the Department of Health poses the roadmap for coordination, planning and management of IMCI programs focussing on child health care services in Papua New Guinea.

The policy provides context and direction of what needs to be done by all stakeholders that are involved in child health. It will provide directions to the child health service providers, families and communities. The policy also includes goals, objectives and strategies to guide implementation of the IMCI strategy in Papua New Guinea.

The basis of this policy is derived from the National Health Plan 2011-2020 which calls for greater participation at all levels of health care in efforts to reduce child morbidity and mortality. The IMCI was indicated as a key strategy to address treatable and preventable childhood diseases such as pneumonia or diarrhoea. The policy advocates for collaboration and consultation with all child health stakeholders to strengthen partnership and to establish network among these agencies and partners.

Integrated Management of Childhood Illnesses Policy developed by the Department of Health poses the roadmap for coordination, planning and management of IMCI programs focussing on child health care services in Papua New Guinea.

Under five mortality rate is 75 per 1000 live births according to DHs of 2006. Invariably deaths occur in hotspots identified already and that simple interventions are available in PNG. To redress this use of some of these interventions like for example use of measles vaccine to eradicate measles disease, or supply of oral rehydration salt to mother for her infant to drink at home to prevent dehydration can help save lives. Majority of these children live in rural areas and the desperate situation for this policy to guide managers and like to fast track its implementation is long overdue.

The three main components of IMCI is; training, system support and community anticipation programs complement each other in reducing morbidity or at least mortality from the 10 common conditions seen in facilities throughout PNG. Specific interventions such as in-service training, vaccination and antibiotic administration further decrease mortality annually.

It is anticipated that IMCI policy would be available in 2014, human resource capacity, as well as funding for infrastructure development/accommodation by 2015 and onwards and recruitment to begin in 2015 and onwards.

Once this policy is ready all Managers and those acting in that capacity will be able to drive the implementation at all levels of NDOH, Provincial, District and Community levels. The areas of responsibility being the interest of monitoring and evaluation and performance based on achievements of those indicators. Some of which are governance, case fatality rates, deliveries and live births, referrals and number alive, antibiotic availability in facility and ultimately culminating in under five mortality rates.

CHAPTER ONE: BACKGROUND

1.1 Intent of Policy

The intent of this policy is to provide a roadmap for coordination, planning and management of IMCI programs in order to improve quality of child health care services in Papua New Guinea.

1.2 Historical Context

For decades, thousands of children have been dying in Papua New Guinea from easily preventable diseases such as pneumonia, malaria and diarrhoea. Until the new millennium, the under 5 mortality ratio in Papua New Guinea according to Inter-agency Group for Child Mortality Estimation (IGME) was still unacceptable high and exceeded 70 deaths per 1000 live births. The similar situation had been observed in many other developing countries.

In order to address poor access of children to health services, high rates of malnutrition and abuse of children, the United Nation General Assembly passed a resolution 44/25 on 20th of November 1989 about Rights of Children and recommended its enforcement in all countries of the world. In March 1993, Former Prime Minister of Papua New Guinea, Sir Rabbie Namaliu ratified the Convention on Rights of Child. After the ratification of the Convention, a Parliamentary Committee for Monitoring of the Situation of Women and Children was established.

Article 24 of the Convention states that in order to implement the rights of children, Papua New Guinea has to provide and promote primary health care to focus on prevention of childhood diseases (section 2, subsections a-f). The National Department of Health (NDoH) has been addressing these issues by developing guidelines and standards for child health care. In 1993, the PNG Paediatric Society recognized the need for more integrated and systematic approaches in diagnosis of childhood illness and developed clinical algorithm called 10-step check list. It was one of the first clinical guidelines developed in the world that addressed main childhood illnesses in one diagnostic and treatment algorithm.

In 1990 United Nation launched Millennium Development Goals Declaration that called for reduction of child mortality by 2/3 between 1990 and 2015. The Government of Papua New Guinea committed itself to achieving this goal by ratification of the Millennium Development Goals Declaration.

In the late 1990s the World Health Organization developed a new approach towards child health called Integrated Management of Childhood Illness. The concept was introduced to the Government of Papua New Guinea at the beginning of 2000. The 10 Step Check List For ALL Sick children was revised to comply with internationally recommended standards and 8 step check list addressing sick infant birth - 2 months as added in 2004.

IMCI strategy was introduced in pre-service training in 2006-2008, however within adequate support from national level. In-service IMCI training was also roll-out through the country, but without proper quality ensures system and accreditation by the National Department of Health.

The IMCI strategy was initially implemented in 2 districts of Papua New Guinea: Madang in the coastal area and Heganofi in the highlands. Lessons learnt from this pilot programme helped to understand challenges with roll-out of the programme and identify the best approaches to address child health at primary health care level.

Based on results of IMCI Health Facility Survey conducted in 2007 and Maternal Newborn and Child Health Delivery Channel Household Survey, it was recognized that implementation of IMCI was too much focused on clinical skills of health workers and not much attention was focused on other components of IMCI strategy such as improving community and family practices and strengthen health system to support for managing child health programs. Lack of access to life saving interventions such as treatment of pneumonia, malaria and

ANNEX TWO: PERFORMANCE MEASURE

Table 1. IMCI Policy Issues and Performance Measure

Policy Issue	Performance Measure	Data Source	Frequency of Measure
Planning	Percentage of Provincial AAP that include IMCI-3 components	Policy and Project	annually
Indicators and Resources	Percentage change in coverage for IMCI interventions	Routine Health Information System	Annually or 5 yearly
	Percentage of Family Health budget allocated to IMCI Activities	Finance & Management Section	Annually
Workforce	Number of Provinces with a full time Paediatrician in Provincial Health Office	Human Resource Information System	Annually
	Number of IMCI Coordinators job filled verses number of IMCI positions vacant at all levels of government system	Human Resource Information system	Annually
	Number of IMCI trained and graduated	SMHS, PAU, DWU, Nursing and CHW Schools	Annually
Partnerships	Number of Community IMCI settings	Healthy Islands VHV& C/CIMCI data base	Annually
	Number of Communities with partnership established implementing IMCI	NGO D/base	Annually
Partnerships	Number of Community IMCI settings	Healthy Islands VHV& C/CIMCI data base	Annually
	Number of Communities with partnership established implementing IMCI	NGO D/base	Annually
Access to child survival interventions	Number of IMCI basic essential drugs, equipment and supplies ordered	MSIV Pharmaceutical Services	Annually
Communication	Number of training materials revised, printed and distributed	Family Health Section	Annually & Special Survey
	Number of Community IMCI cards, posters and other IEC materials printed and distributed to Province, District and LLG (families)	Family health Section & HIS	Annually
Monitoring & evaluation	Number of AAP IMCI activities implemented	Family Health Section	Annually
	Percentage number of interventions implemented	Family Health Section	Annually/ special survey
	Percentage increase in coverage by each intervention tool used	NHIS & FHS	Annually or special survey
	Number of cases of target disease admitted/discharge /deceased	National Health Information system and Family Health Section	Annually
Governance	Number of meetings conducted at National, Provincial, District and Communities	FHS & IMCH Coordinators	Annually
Supervisory & Follow-Up visits	Number of supervisory, follow up visits and training conducted	FHS & IMCI Coordinators	Annually

Provincial IMCI Coordinator or Focal Person is to be responsible for

- Facilitating the policy and strategic directions and allocation of resources and implementation at provincial and district levels
- Coordination and monitoring of IMCI activities in the province and districts; and
- Collation of data, entry and analysis of IMCI indicators

District IMCI Coordinator and Focal Person is responsible for

- Coordinate and schedule workshops and meetings for participants at the district level
- Coordinate planning and allocation of resources for the implementation of IMCI activities in different communities of the district
- Supervise and monitor the planned activities and provide feedback to local authorities including Provincial Health on regular basis
- Collaborating with partners to improve coverage in key family practices and behavioural changes
- Recommending staff for capacity building and training in administering the community and IMCI programs.

Community Leaders

- Mobilise the community for any child health activity such as village registrations and immunization programs
- Participate in community IMCI strategy development, planning and implementation
- Serve as conductors of information between health facility and the community; and,
- Work together towards improvement in quality of service

Local and International NGOs

- Participate in community IMCI subgroups or coordinating committees at all level
- Participate in the planning process at all levels
- Serve as implementing partners of the community IMCI programs and provide financial and technical support to community IMCI
- Develop methods or foster links between health facility and communities and assist government with building capacity to coordinate and implement community IMCI and test new innovative approaches to improving key family practices.

Development Partners

- Work with government institutions at all levels by aligning their planned programs to support government priorities

diarrhoe in rural areas within health facilities was also identified as priority issue. This creates the base implementation of community IMCI services to be provided by volunteers and non-health professionals such as Village Health Volunteers in 2009

Despite efforts and commitment of health professionals to reduce child mortality and morbidity, due to lack of political commitment to roll-out IMCI strategy and limited funding for child health, many provinces showed very slow decline and not allowing for achieving MDG 4. In 2006 the under-five mortality rate of 74 per 1000 live births was still remaining as one of the highest in the Western Pacific Region. In 2010 the Minister of Health launched the National Health Plan 2011-2020 that indicated IMCI Strategy as the key strategy to reduce child mortality and morbidity due to common childhood illnesses like pneumonia (Key Result Area 4, objective 4.4, strategy 4.4.1; 4.4.2 and 4.4.3). Recognising the IMCI strategy as one of the key approaches to accelerate reduction of the child mortality in Papua New Guinea opened a new chapter of implementation of IMCI strategy in the country, that started with development of IMCI Policy and updating IMCI clinical guidelines to include HIV/AIDS, breastfeeding assessment, WHO growth standards and new malaria diagnosis and treatment procedures. The IMCI strategic implementation plan was also developed to support implementation of the IMCI Policy across the country.

1.3 Audience

This policy document is intended to guide all health professionals, managers, decision makers and partners involved in child health care such as:

- National Department of Health;
- Other governmental institutions and agencies including Central Agencies, Provincial and District Administration and Local Level Governments;
- Managers of health services;
- All health workers managing children either in private or public health services;
- Relevant stakeholders and development partners;
- Non-Government Organisations/Faith Based Organisations;
- Any other institutions and individuals interested in child health care.

1.4 Policy Development Process

The policy was initiated after analysis of data on quality of care delivered to sick children in two districts (Madang and Henganofi) that piloted implementation of the IMCI strategy in PNG. The findings revealed that successful nation-wide roll-out of the IMCI programme require proper policy framework assigning responsibilities for implementation of specific activities to appropriate levels and partners and guiding provincial and district health authorities on implementation process. The first draft of the Policy was developed in 2007 and presented at the PNG Paediatric Society in Wewak, followed by another meeting in Loloatain 2009. The review of the draft from this meeting was later presented during Medical Symposium Paediatric Society Meeting in Kimbe. The draft was received warmly and further developed after series of meeting with various stakeholders. Three technical stakeholders meetings were conducted in June and November 2012 in Bluff Inn and one at the Sogeri Lodge in July 2013 to complete this policy.

The development of the Policy was a consultative and teamwork oriented process with emphasis on actions specific for Papua New Guinea settings and environment.

CHAPTER TWO: POLICY CONTEXT AND DIRECTIONS

2.1 Goal

The Goal of this policy is to reduce child mortality and morbidity rates and to improve growth and nutrition of children in Papua New Guinea through quality and timely implementation of IMCI programs.

2.2 Vision and Mission

The **Vision** of the Policy is to have a nation consisting of healthy children, families, and communities that upholds human rights, Christian and traditional values with all children having access to affordable, culturally acceptable health services complying with international standards.

The **Mission** is to improve quality of care of children through transformation of health services to follow IMCI approach, focusing on improvement of health Workers skills, better health system support and improved child health care practices at family and community levels.

2.3 Objectives

The objectives of the IMCI Policy are:

1. To improve quality of care delivered to children at Primary Health Care Facilities through training of health worker managing children in Integrated Management of Childhood Illness and sustaining their skills through refresher courses and supervision.
2. To improve child care at community level by better family and community practices in prevention of diseases and supporting health growth and development of children.
3. To improve access to quality health care by improving early diagnosis and treatment of child diseases at community level including referrals.
4. To ensure that the Health System supports provision of child survival intervention through reliable supplies of essential drugs, availability of lifesaving equipment and better organisation of work.

ANNEX ONE: ROLES OF STAKEHOLDERS OF THIS POLICY

National Department of Health

- To be responsible for the overall policy development, review and coordination of IMCI components, mainly 1 & 2 and some aspects of community IMCI
- Enforce laws, regulations, IMCI policy and support community IMCI in PNG
- Maintain the standards of IMCI training materials in line with curriculum development and standards of the training institutions.
- Printing and logistic support on IMCI materials and supplies required for training
- Procurement and distribution of essential drugs supplies and minimal paediatric advanced life support essential equipment and support system throughout PNG
- Coordination of community IMCI in planning, implementation and monitoring so that geographical areas can sustain it.
- Co-ordinate and conduct evaluation process of all components of IMCI

The Provincial Administration/Provincial Health Authorities

- Facilitate the establishment of Provincial and District Coordinating IMCI Committees
- Guide the provincial and district planning process, including written plans for each level for training, system support and community IMCI
- Ensuring that all three components of IMCI are implemented and mutually reinforcing
- Take responsibility for coordinating community IMCI implementation, including administration and financial management and coordination of training IMCI in the province
- Supervise CHW to conduct baseline data on community diagnosis and or indicators to monitor programs in the communities and evaluate on annual basis
- Ensure capacity building for staff or in-service is supported through funding and appropriate management

The District Administration

- Maintain liaison of activities between ward communities and district office
- Maintain linkages with other development partners and line agencies including NGOs such as churches, women and youth groups and community to foster holistic approach
- Decision making about funding for IMCI health activities and may be incentive/reward for CHW
- Ensure Implementation of activities using participatory problem solving process to assess needs
- Ensure Collation of information, data and action to be on regular basis at the facilities and community base
- Ensure community capacity development is linked to health care providers and health systems. This is to restore social mobilization, monitoring and development of family practices and or IMCI interventions

Health Workers (specifically to child Health)

Currently the Technical Advisor Child Health (TACH) is synonymous with National Coordinator, or IMCI focal person in PNG

- Will be responsible for Policy and Strategic directions
- Will Manage, Facilitate and allocate resources for the implementation of IMCI activities including orientation workshops, meetings and evaluation
- Monitoring of the IMCI activities at the National and Regional levels; and
- Will be responsible for evaluating the IMCI activities at a regular level in the country

CHAPTER FIVE: MONITORING AND EVALUATION

5.1 Monitoring and Evaluation

Monitoring and evaluation is a continuous assessment to ensure objectives of the IMCI policy is met for continuous quality improvement.

Implementation of the policy at each province, district and community will be monitored at the national level. Data for such will be conducted through routine information collection and through special survey for specialized information.

Data is collected by health facility staff on routine information data forms and reported through the system. Where it is necessary and on request, the NDOH will review health information system and expand its data collection system to accommodate for IMCI policy.

IMCI policy performance measure will require monitoring on annual basis as listed in table one (1) below.

5.2 Review Arrangements

NDOH will monitor this policy implementation through the Monitoring and Evaluation Unit and assisted by the Policy Planning and Family Health Branch of the National Department of Health. The outcome is to be presented on annual basis and in-line with the mid-term reviews of the National Health Plan 2011 – 2020

2.4 Principles

Child Health Services shall be delivered with consideration of human rights, Christian and traditional values that put welfare of Family and community in the centre of our daily life. The Child Health Services should cover not only urban areas but also focus on rural majority and marginalised populations. It should be characterised by professionalism, loyalty, integrity, courage, innovation and teamwork.

All IMCI activities and programs shall be guided by the following principles:

1. **Rights of children to good health care:** where every child can enjoy healthy growth and development and can use health care services to protect and treat them against any disease or disability.
2. **Equitable access to quality health care:** where every child regardless of social status, cultural background, tribal ethnicity, geographical setting and urban or rural livelihood is given the same quality of health care services.
3. **Holistic and integrated approach:** where every child is receiving comprehensive care combining provisions of different child health interventions at the same time when required
4. **Gender Equality:** where every child regardless of sex as well as gender and sex of their caregivers, has equal access to quality health care services.
5. **Evidence based services:** where every child is receiving health interventions that are proved to be effective, documented and internationally recognized.
6. **Good Governance:** where implementation of IMCI program and activities complies with relevant government processes and legislations.
7. **Transparency:** where information on IMCI programs and activities are openly shared amongst all relevant stakeholders.
8. **Accountability:** where IMCI programs are monitored and relevant stakeholders are liable for their implementation results.
9. **Leadership and ownership:** where the State takes responsibility for the overall policy coordination and implementation.
10. **Sustainability:** where programs and interventions after initial support of development partners can be successfully continued with available resources and capacity.
11. **Cost Effectiveness:** where allocated funds and other resources justify achieved results.
12. **Friendly services to children and caretakers:** where all children and their caretakers can receive health care services in supportive, empathetic and hospitable environment.
13. **Participation of communities:** where caretakers and local leaders are involved in decision making process on issues affecting children's access to quality health care.
14. **Partnership:** where IMCI programs and activities are implemented through effective dialogue and collaboration with all relevant child health stakeholders.



2.5 Core Government Legislations and Policies

The Policy was developed in line with priorities of National Health Plan 2011-2020 and was consulted and guided by the following documents and legislations:

Laws and Acts

1. Papua New Guinea Constitution; 1975
2. Public Hospital Act; 1994
3. Public Finance Management Act; 1995
4. National Health Administration Act; 1997
5. National Drug Policy of Papua New Guinea; 1998
6. Organic Law for Provincial and Local Level Governments; 1998
7. HIV Management and Prevention Act; 2003
8. Provincial Health Authority Act; 2007
9. Baby Food Supply Act 1977 amended 1984;

Policies and Standards:

1. Health Sector Human Resource Policy; 2012
2. National Health Plan 2011-2020; 2010
3. Child Health Policy; 2010
4. Vision 2050; 2009
5. Family Planning Policy; 2009
6. National Policy on Medical Equipment for Papua New Guinea; 2004
7. National Policy for Expanded Program on Immunization; 2004
8. Minimum Standards for Village Health Volunteers in Papua New Guinea; 2003
9. Minimum Standards for District Health Services in Papua New Guinea; 2003
10. National Policy on Health Promotion; 2003
11. National Tobacco Control Policy; 2003
12. National Policy on Partnerships in Health Sector for Papua New Guinea; 2002
13. Medical and Dental Stores Catalogue; 2002
14. National Population Policy 2001- 2010; 1999
15. National Family Planning; 2014
16. Papua New Guinea National Nutrition Policy; 1995
17. Medical and Dental Catalogue; 2012
18. National Health Service Standard; 2011



CHAPTER FOUR: IMPLEMENTATION PLAN

4.1 Implementation Arrangements

This policy will be implemented by all levels of the health system in a more coordinated manner for better outcomes as envisaged in this policy.

Detailed roles, responsibilities and expectations are outlined in Annexure one (1) of this policy and detailed activities in implementing this policy is outlined in the Implementation Schedule in Annexure five (5).

The IMCI Technical Advisory Committee will provide overall technical advice and governance framework to meet standards and quality services. The Family Health Services through the Health Secretary will provide overall technical leadership and guidance by advocating and advising respective implementers through circular instructions, policy coordination and advocacies on IMCI programs throughout the health system.

The public health system will plan and budget for resources for implementation through normal government existing planning and budgetary processes. At the national level, the NDoH will incorporate main strategies into the Child Health Strategic Plan and NDoH Corporate Plan and operationalize these activities annually through the Annual Implementation Planning (AIP) and budget appropriations.

Provinces, Provincial Health Authorities and the Provincial Hospitals will implement this policy by incorporating strategies and activities of this policy into their 5 year Provincial Health Strategic Implementation Plans, 5 year Provincial Health Authorities Strategic Implementation Plans and 5 year Hospital Strategic Implementation Plans respectively. Operationalization of this policy will be on annual basis through the normal AIP and budget appropriations.

Others partners will implement this policy in their own settings, but are encouraged to work with respective government agencies where they operate from in a coordinated manner as outlined in the Health Sector Partnership Policy. This will bring about better health outcomes through maximisation of limited resources in strategic priority activities.

4.2 Resource, staffing and service implications

The current poor outcome of IMCI services reflects lack of commitment in funding, staffing and service provision. This policy outlines strategies that will be undertaken during the term of this policy to improve the current situation.

Implementation of the strategies requires increase funding at National, Provincial, District and more so at the local level where the majority of Papua New Guineans live. Increase funding is required to ensure quality service is provided throughout the Health service delivery system. This means undertaking visits from higher levels to lower levels for the purpose of supervisory, monitoring and capacity building of staff. Increase funding will contribute to increase staffing, retention and remuneration packages and equipping staff with necessary equipment and tools which will have positive impact on service provision.

3.2.14 IMCI and other child health oriented programs

The potential of IMCI strategy will complements or align other child health priority programs such as malaria, HIV/AIDS, nutrition, EPI, oral health, other skin diseases and infestations with intestinal worms not recognized or utilized and others to its full potential.

IMCI strategy will complement or align to other priority child health oriented programs.

Strategy:

1. NDoH, Provinces, Provincial Health Authorities and partners ensures IMCI strategy complements and or align to other child health programs such as malaria, HIV/AIDS, nutrition, EPI, oral health, other skin diseases and infestations with intestinal worms and others not recognized or utilized to its full potential.

3.2.15 Data to support implementation of IMCI at local level

Successful implementation of IMCI strategy requires access to quality data about problems and barriers limiting quality and access to child survival interventions. Such data are essential to feed the IMCI program planning and management cycle necessary for better implementation of IMCI strategy on the local levels. The capacity to conduct IMCI Health Facility Survey as well as MCH Household Survey should be available at the provinces and districts and utilized when needed. Adequate resources should be secured for monitoring and evaluation of IMCI programs on national, provincial and district levels.

Planning and implementation of IMCI programs shall be evidence based and guided by locally available data.

Strategies:

1. NDoH will advocate for Provinces, Provincial Health Authorities and partners to support capacity to collect data on implementation of IMCI Strategy at all levels of health system.
2. NDoH will advocate for, Provinces, Provincial Health Authorities and partners to make available data to support planning and implementation of IMCI strategy
3. NDoH will advocate for Provinces, Provincial Health Authorities and partners to use data on coverage of IMCI interventions and quality of care delivered to sick children to guide planning and implementation of IMCI strategy.
4. NDoH will promote research in IMCI strategy to support its effectiveness and better implementation of the IMCI program.

CHAPTER THREE: POLICIES AND STRATEGIES

3.1 Current Situation

According to the Demographic and Health Survey conducted in 1996 and 2006, the under-five mortality dropped down from 92 per 1000 live births to 75 per 1000 live births, respectively. Although the under 5 mortality rate in Papua New Guinea is steadily reducing, it is still unacceptably high and remains as one of the highest rates in the Western Pacific Region. According to UN Inter-agency Group for Child Mortality Estimation, based on analysis of all available data regarding child health, that under five mortality was 58 deaths per 1000 live birth in 2011 with 2.0 annual reduction rate, too slow to achieve Millennium Development Goal 4 (29 death per 1000 live births) in 2015.

The 2000 Community and House Hold Survey conducted by the PNG Institute of Medical Research confirmed that many children in Papua New Guinea were dying from easily preventable and treatable diseases such as pneumonia, malaria and diarrhoea. Malnutrition rates were also found to be high. The study showed that mothers were lacking basic knowledge about recognition of danger signs and were reluctant to bring their sick children to the health facility on time. The survey pointed out that many first line health facilities such as Aid Posts were closed and those that were operating did not have essential medicines and equipment.

The study on neonates conducted in Wosera in East Sepik Province in 2001, showed that many babies died due to infections, hypothermia, hypoglycaemia and low birth weight including prematurity. Malnutrition was also strongly associated with increased risks of dying.

The National Nutrition Survey conducted in 2005 revealed high prevalence of stunting among children that was exceeding 50% in Momase Region. The same survey showed that around 18% of children were underweight and another 5% were estimated to be wasted. Vitamin A deficiency also remained a significant problem with prevalence of 26% among children 6-59 months of age. The other findings include high rates of anaemia in children in Momase reaching 67% and 56% in Southern Regions and low proportion of children exclusively breastfed for first 6 month of life with 80% of children having complementary feeding introduced before recommended age of 6 months.

The high prevalence of stunting was also confirmed in the Household Expenditure Survey conducted in Papua New Guinea in 2010. The nutritional practices were found to be poor despite including assessment of malnutrition, anaemia and plotting growth charts in the IMCI algorithm.

The evaluation study on IMCI done by PNGIMR in 2006 based on interview of health workers in pilot and controlled areas showed that staff trained in IMCI performed much better in the clinical management of childhood illnesses such as diarrhoea, pneumonia, anaemia, and were able to pick up certain issues such as incomplete immunisation.

The 2007 Health Facility Survey conducted in IMCI pilot and control areas based on observation of case management confirmed that the quality of assessment of sick children was much better in the group of staff trained in the IMCI strategy compared to those not trained in integrated management of childhood illnesses. However the same survey showed that some elements of IMCI assessment were still not performed by majority of the trained staff including assessment of feeding practices. This finding calls for improvement of quality of trainings and for follow up visits after training to be considered as "integral part of the IMCI training". The health facility survey also revealed that high proportion of children that needed referral was not referred and lack of supervisory visits from higher level facilities.

The 2007 IMCI Health Facilities Survey also confirmed previous reports and observation showing that many facilities were not equipped with IMCI essential drugs and equipment. The aid posts were much more affected by shortage of drugs than health centres and sub centres. IMCI trained staff working at aid posts were able to identify children who required vaccinations, but could not update their immunization status due to unavailability of vaccines and cold chain system at the aid post level. In addition many aid posts remained closed limiting access to child health services at the community level.

These findings were confirmed by MCH Delivery Channel Household Survey conducted in the same area in 2010 showed that coverage of many child survival interventions (for example Vitamin A supplementation or early diagnosis and treatment of malaria) remained low at the community level.

It is important to note that development partners never recognised IMCI as priority strategy to approach child health in Papua New Guinea despite clear direction and request from the Government. As a result IMCI had never got recognition in terms of funding.

The above findings presented in the light of high child mortality in the Papua New Guinea showed very slow expansion of IMCI programs due to various reasons that are discussed in detail in the chapter on Analysis of Issues.

This calls for IMCI interventions to be urgently implemented to meet the Millennium Development Goal 4 and other commitment of Government towards child health declared in the National Health Plan 2011-2020 and other documents and declarations, including Convention of Rights of Children.

3.2 Analysis and Policy Statements

Papua New Guinea faces many challenges that contribute to the high under five mortality and its slow decline in the last decades. The various findings from surveys and studies discussed in chapter 3.1: **Current Situation** identified several challenges and problems that needed to be addressed to ensure effective implementation of IMCI strategy.

3.2.1 Political and funding commitments

Implementation of IMCI policy requires substantial resources and support from government and development partners. Current experiences shows little commitment offered to roll-out all components of IMCI policy throughout the country. Political support is necessary across all levels of government to prioritize and support effective implementation of IMCI programs at all levels of the health system.

IMCI shall be a priority to reduce mortality and morbidity and support healthy growth and development of children under age of five. It requires strong political support and commitment at all levels of government.

Strategies:

1. IMCI programs will be advocated for political support at all levels of government.
2. All development partners and including other relevant stakeholders will be informed about IMCI policy and status of its implementation.

All Health Workers managing children should have appropriate skills and knowledge to implement IMCI interventions at all health facilities.

Strategies:

1. NDoH to ensure that IMCI knowledge and skills are included in pre-service curriculum in all medical and nursing schools in the country.
2. NDoH to advocate for provinces and Provincial Health Authorities and partners to ensure that every health worker managing IMCI programs has completed IMCI in-service training including refresher.
3. Family Health Services to advocate for establishment of Regional Training Centres for IMCI strategy.
4. NDoH will advocate that follow-up visits after training are considered as an integrated part of the IMCI training.
5. NDoH will ensure IMCI training materials are updated to meet current practice
6. NDoH, Provincial Health Authorities and Provinces to ensure all health workers trained in IMCI strategy are registered and acknowledged.

3.2.12 Postgraduate training in management of IMCI programs

Coordination of IMCI programs require deep knowledge and managerial skills on implementation and monitoring of IMCI strategy on national, provincial and district level. There are no post graduate courses in Papua New Guinea that can prepare a proper cadre of the staff (health managers) capable for implementation of IMCI programs at provincial and district levels. This should be addressed by establishing post-graduate training programs for IMCI officers and provincial and district coordinators.

Every IMCI coordinator shall have qualification and skills in managing IMCI programs

Strategies:

1. NDoH will advocate and liaise with other relevant stakeholders for establishing post graduate training for IMCI coordinators.
2. NDoH will advocate for provinces and PHAs to ensure that every IMCI coordinator has skills to implement IMCI programs at provincial and district levels.

3.2.13 IMCI and Private Sector

There is limited impact of IMCI strategy on quality of care delivered to sick children in the private sector. There should be strategies developed to include the private sector in implementation of IMCI strategy.

The private health sector shall be encouraged to actively participate in the implementation of IMCI programs.

Strategy:

1. NDoH, Provinces and PHAs promote adoption of IMCI strategy as part of the private health services programs.

3.2.9 Access to child survival interventions at community level

There is limited access to essential child survival interventions at community level (such as access to lifesaving treatment for malaria, pneumonia and diarrhoea) due to: closure of aid posts, extreme geographical conditions, limited access to health facilities and unavailability of health staff at community level. Outreach programmes to access remote communities are difficult and cannot be available when curative interventions are urgently needed. This could be addressed by introduction and roll-out of “Community IMCI programs” based on local volunteers and retired health workers ready to provide lifesaving intervention to children when needed and support referrals to the nearest health facility.

Every child at community level should have access to basic and lifesaving treatments for common illnesses.

Strategies:

1. Provinces and Provincial Health Authorities support Community Health Posts and Aid Posts to have all required IMCI basic essential drugs, equipment and supplies and have staff equipped with skills to provide basic lifesaving treatments.
2. Provinces and Provincial Health Authorities to advocate for Community IMCI programs to be established in each community without regular access to health services.
3. Provinces and Provincial Health Authorities work with each community without access to formal health services have volunteers trained in provision of basic lifesaving treatment and referring of sick children to health facilities.
4. Provinces and Provincial Health Authorities to ensure that every IMCI village volunteers have appropriate skills and knowledge to manage sick children at community level and to referring them when required.
5. Provinces and Provincial Health Authorities to ensure support from Community Aid Posts or other relevant health facility for village health volunteers/village health workers to implement Community IMCI programs.

3.2.10 Good Governance and Good Practices

The IMCI strategy currently is not implemented in a sustainable and cost-effective way. This can be addressed by building national, provincial, district and local capacity for implementation of the IMCI strategy using good governance and good practices.

IMCI programs shall be implemented in line with principles of good governance and good practices at all levels.

Strategies:

1. NDoH will work with PHAs and Provinces to ensure all IMCI programs have adequate mechanisms for proper governance.

3.2.11. Training of Health workers on IMCI skills and knowledge

Current training approaches used for scaling up IMCI interventions through ad hoc IMCI trainings limited by lack of resources, high costs of training and unavailability of qualified trainers, result in low numbers of trained staff and poor outcomes of conducted training. Establishing “Regional Training Centres of Excellence in IMCI” providing continuous, cost-effective and high quality trainings should become a sustainable way of building human capacity to implement IMCI interventions. The “Regional Training Centres of Excellence in IMCI” should be involved in both pre- and in- service training and should coordinate and be supported by National level.

3.2.2 NDoH Stewardship role in coordination of IMCI programs

Despite committed resources and efforts of government and development partners to reduce high under-five mortality, there was not much improvement observed in the last 3 decades. This was due to lack of clear policy directions and coordination between the different levels of governments (central agencies, national, provinces, districts and local levels of governments), development partners, Non-Government Organisations and other relevant stakeholders. Effective coordination to avoid potential duplication of responsibilities should allow for maximisation of limited resources towards achieving agreed goals and outcomes. This means NDoH has to take leadership as the steward of the health system to coordinate IMCI programs by providing guidance to implementers as well as advocacy on resource throughputs into the health system.

NDoH shall strengthen its stewardship role and maintain effective coordination of IMCI programs in the country.

Strategies:

1. NDoH advocates for planning and implementation of IMCI programs in provincial, district levels and local levels of governments are guided by the National Health Plan, National Health Service Standards and the IMCI Policy.
2. NDoH ensures information on status of IMCI implementation is collected through National Health Information System and other data not captured by NHIS be collected through research and surveys.

3.2.3 Capacity to implement IMCI at provincial and district levels

There are no proper mechanisms existing and local capacity that allow for coordination and supervisions of health staff managing children according to IMCI standards. Creating and filling of positions for IMCI coordinators at district and provincial level would build local capacity for successful roll-out of IMCI programs.

All Provinces, Districts and LLGs shall build and strengthen their capacity to effectively implement IMCI programs

Strategies:

1. NDoH will advocate for lower levels of government to build technical and managerial capacity to implement IMCI programs at provincial, district level and LLG levels.
2. All responsible management teams ensure adequate human and financial resources are available at all levels of health delivery to implement IMCI programs.
3. All health workers managing sick children to be equipped with skills and knowledge to implement IMCI.

3.2.4 Essential medicines, IMCI equipment and consumables.

Unavailability of IMCI essential drugs and equipment, as well as lack of cold chain for vaccinations at health facilities contributes to missed opportunities for the staff to provide the services when the need is identified. A sustainable and reliable medical supply system supporting IMCI service delivery, especially in rural and remote areas, is important for increase in coverage of child survival intervention and achieving better child health outcomes.

Every Health Facility shall have essential medicines, equipment and consumables required for implementation of IMCI services.

Strategies:

1. NDoH to ensure every health manager is made aware of essential medicines, equipment and consumables required for implementation of IMCI services.
2. All health facilities managing children should be adequately stocked with essential IMCI medicines, equipment and consumables.

3.2.5 Supervisory visits

There is lack of supervisory visits from higher levels to monitor IMCI activities and to provide support to the staff at health facilities. This leads to missed opportunities to maintain and improve quality of integrated child health services. The supervisory visits should also include supervision of child health care providers at community level practising community IMCI.

Every health facilities shall receive supervisory visits at least once every quarter.

Strategies:

1. NDoH will work with provinces, public hospitals and Provincial Health Authorities and other partners to ensure they have capacity to provide supervisory visits to support implementation of IMCI strategy at the health facility level.
2. All Provinces, Provincial Health Authorities and districts ensures that every facility managing children receives supervisory visits at least once per quarter.

3.2.6 Referral of critically sick children

Poor functioning referral system often lead to critically sick children not being referred to the higher level of health care. This includes lack of effective communication between health facilities, lack of transportation, inadequate financial capacity, poor compliance from caregivers and lack of commitment from communities.

Every sick child needing referral shall be promptly referred for appropriate care and treatment.

Strategies:

1. All health management teams need to establish effective communication and transportation systems to support referrals.
2. All health facilities advocate for Community Participation in supporting referral of critically sick children at all levels.
3. NDoH will work with provincial Health Authorities, Provinces and public hospitals and other partners to ensure all sick children requiring referral to be appropriately managed.

3.2.7 Quality of care at referral level

There is lack of essential equipment such as oxygen therapy and lack of adequate skills to provide lifesaving procedures to critically ill children at the referral levels. This contributes to high mortality rates in children less than 5 years old in the group of children already referred for higher level of care.

Every Health facilities receiving referrals shall have capacity to provide life - saving procedures.

Strategies:

1. NDoH will work with provinces, Provincial Health Authorities and public hospitals to ensure that every health facility manager and health worker is familiar with equipment and lifesaving procedures at referral level.
2. NDoH will work with provinces, Provincial Health Authorities and public hospitals to ensure that at all referral health facilities are properly supplied with equipment and medicines needed for care of critically sick children.
3. NDoH will work with provinces, Provincial Health Authorities and public hospitals to ensure every health worker at referral level health facility have skills and knowledge to provide lifesaving procedures including oxygen therapy and resuscitation.

3.2.8 Community and family practices

Lack of good family practices such as proper health seeking behaviour or appropriate nutrition practices, contributes to high under five mortality rates observed in the past three decades. There is evidence that successfully implemented IMCI preventive and curative interventions at community levels have long term benefits for health and wellbeing of children.

Awareness, knowledge and skills in early recognition of danger signs in children are very important. Practising of harmful traditional and cultural habits that delay referral are considered to remain significant barriers for accessing quality health care services by sick children.

Every family should have knowledge and skills to prevent common childhood illnesses and to support healthy growth and development of children.

Strategies:

1. NDoH will advocate and work with province, Provincial Health Authorities and public hospitals to ensure there is capacity at respective local levels to provide awareness and knowledge and to teach skills on prevention of common childhood illnesses and to surport and promote nutrition.
2. NDoH will advocate and work with province, Provincial Health Authorities, public hospitals and partners to ensure awareness and education campaign to improve family and community practices is conducted in each community, in the country.
3. NDoH will advocate and work with province, Provincial Health Authorities and public hospitals and partners to ensure that there are mechanisms in place to provide supplies and IEC materials to support implementation of child health preventative oriented interventions at community level.
4. Ensure that every care giver of the sick child is properly informed about proper community and family practices to ensure healthy growth and development of children
5. Ensure that every care giver has knowledge and skills to recognise danger signs that require visit to health facility.