



# Integrated management of newborn and childhood illnesses: Between failure and resurrection, a real opportunity for child health

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## Abstract

In Cameroon, vertical key programs considered as flagship health programs compete the strategy of "Integrated Management of Newborn and Childhood Illnesses" (IMNCI). The IMNCI guide contains all the recommendations for effective implementation at a lower cost. Meanwhile, less than 20% of health districts has health facilities with at least 60% of staff skilled in IMNCI, threshold required for its measurable impact on child survival. The leadership in IMNCI is questionable; its interventions are not only confused with those of key programs, but also overlap in different departments of the Ministry of Health. The challenge revolves around locating sustainable funding sources to expand IMNCI. Its introduction into the academic programs of training institutions is among cost-effective solutions. Elsewhere, it requires the pooling of resources of the key programs in a common basket fund. The advantages brought by IMNCI represent a real opportunity for the Cameroon health system, so to reverse the oblivion it is suffering. The indifference IMNCI suffers should under no circumstance be judged as a failure without the government having mobilized its own resources to ensure its rebirth. There is a need to resize IMNCI into a wider system of primary health care services institutionalized within the Family Health Department.

**Keywords:** IMNCI, funding, key programs, achievement, failure, opportunity, Cameroon.

## Résumé

**Prise en Charge Intégrée des Maladies du Nouveau-né et de l'Enfant : entre échec et résurrection, une chance réelle pour la santé de l'enfant**

## Résumé

Au Cameroun, les programmes verticaux dits locomotives de la stratégie de «Prise en Charge Intégrée des Maladies du Nouveau-né et de l'Enfant» (PCIMNE) la concurrencent innocemment. Leurs directives sont toutes consignées dans le guide PCIMNE et mises en œuvre efficacement à moindre coût. Cependant, moins de 20% des Districts de Santé disposent des formations sanitaires avec au moins 60% de personnels aptes à mettre en œuvre la PCIMNE ; ce seuil est requis pour que son effet soit perceptible sur la survie des enfants. Le leadership serait en remis en cause ; en effet les interventions concernant la PCIMNE se confondent non seulement à celles des programmes verticaux, mais aussi chevauchent dans différents départements ministériels de la Santé. Le défi actuel consiste à trouver les sources de financements durables afin d'augmenter la couverture en PCIMNE. Son introduction dans le curricula des établissements de formation de base représente l'une des solutions rentables. De plus, elle exige la fédération des ressources balkanisées dans les différents programmes verticaux, orientées vers un fond commun. Les prouesses de la PCIMNE représentent une chance réelle que le système de santé camerounais a l'opportunité de saisir pour renverser les oubliettes qu'elle subit. En effet la PCIMNE souffre d'un manque d'intérêt ; elle ne devrait sous aucun prétexte être jugée sous l'angle d'échec, sans que le gouvernement camerounais n'ait mobilisé ses propres ressources pour favoriser sa résurrection. Il y a une nécessité de redimensionner la PCIMNE dans un système plus large de service de soins de santé primaires institutionnalisés au sein de la Direction de la Santé Familiale.

**Mots clés :** PCIMNE, financement, programmes verticaux, prouesses, échec, opportunité, Cameroun.

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## CONTEXT

The undoubted successes achieved by "Integrated Management of Newborn and Childhood Illnesses" (IMNCI) strategy over the last 30 years position this strategy at the top of the most effective ever known in terms of lives saved or that can be saved when implemented correctly [1]. In Cameroon, several health programs promoting child health unwillingly compete with the IMNCI strategy. Their actions are not in any way coordinated in the field, and each acts according to its own objectives and vision. In fact, the interventions of the key health programs so-called flagship of IMNCI programs are all included in the latter's guidelines and implemented effectively at low cost. IMNCI uses the syndromic approach and prioritizes promotional, preventive, and curative interventions [2]. It thus makes it possible to anticipate the prevention and management of killer diseases in newborns [3]. By combining syndromes into a single algorithm, IMNCI is the most comprehensive strategy for the health and well-fare of the newborn and child. Cameroon adopted it in 1999 and has been implementing it since 2003. The goal was to achieve results that were not possible through keys programs approach. Although health survey results show a decrease in child mortality, however it is not sufficient to enable Cameroon to reach the threshold of at most 25 deaths per 1000 live births set by the sustainable development goals. It is clear that the expected impact of IMNCI in the first few years after its launch may not be noticeable, but it does produce significant long-term results [4]. Its performance depends on the implementation of its three components: improving the skills of health personnel in case management, strengthening the health system as a whole, and family and community health practices.

### Human resources allocations for IMNCI

In Cameroon, less than 20% of health districts have more than 60% of staff implementing IMNCI, this threshold of 60% is required for its effect to be palpable on child health. Furthermore, pediatricians are in far too few numbers and are concentrated only in large urban areas. There are not really enough pools of regional trainers to enable the decentralization of IMNCI management. In addition, polyvalent community health workers are concentrated in only a few health districts. This simply means that the management of children is done essentially in health centers, most of which

operate illegally. The decentralization of IMNCI is essential because it calls upon local leaders and thus fosters accountability. In a context of skilled human resource shortages, where vertical programs compete with such an important strategy, health personnel are less committed to providing services due to the priority given to these programs. Furthermore, the assessment of the fraction attributable to IMNCI interventions would be biased [5].

### The pittance of government funding for IMNCI

Funding undoubtedly represents the main bottleneck for its implementation. Indeed, after its successful pilot phase, IMNCI was admitted to the Heavily Indebted Poor Countries (HIPC) financing initiative, and budget lines were included in the public investment budget for the geographical expansion of IMNCI in 2005. However, government funding only really came into effect between 2008 and 2011. Also, HIPC funds only covered 12 health districts out of the 80 existing. In 2006, the preliminary implementation plan was only partially executed. Due to these shortcomings, financial and technical partners committed to providing support, although also proven insufficient and with an unstable sustainability. While this financial support was only short-lived for some, it was mainly directed towards so-called priority geographical areas and withdrawn insidiously, then progressively, so much so that by 2012, the majority were completely absent.

### Leadership in IMNCI and the scattering of interventions the numerous ministerial departments and programs

It would also be interesting to challenge the leadership regarding IMNCI in Cameroon. At the central level, there is an IMNCI National Working Group (IMCI- WG) that coordinates and guides the implementation of IMNCI at all levels of the national health system. Its interventions are not only muddled with those of key programs but also overlap within different Ministerial Departments, such as the Department of Healthcare Organization and Medical Technology ( DHMT), Health Promotion, and the Family Health Department (FHD). Also, partner funding is directed towards the "community-directed interventions" approach carried by the malaria control program, but housed in the DHMT. In such a disparate context, how can the FHD, which hosts IMNCI, ensure optimal leadership in this area without encroaching on the

subsystems area. It is also important to note that if the IMNCI-WG manages to hold its meetings, their regularity depends on holding them jointly with the national working group for the newborn supported by a multilateral organization. Another difficulty lies in the absence of a formal structure for regional coordination of the strategy.

### **The challenge of scaling up IMNCI**

The current challenge is to find sustainable funding sources and increase IMNCI coverage in at least 80% of health districts with at least 60% of staff capable of managing sick children according to IMNCI guidelines. Its introduction into the academic program of training institutions was a cost-effective solution; however, the teachings remain theoretical whereas the practical phase constitutes a great asset. It is crucial to harmonize training by creating a partnership between training institutions and health facilities labeled "IMNCI". This involves the establishment of trained and empowered focal point in hospital for this purpose.

Due to the growing complexity of IMNCI management, a comprehensive assessment would determine the key obstacles to its implementation [6]. From the lessons learned from this evaluation, solutions stemming from the health system [7] would emerge, allowing Cameroon to restore this strategy full potential, which is the significant improvement of neonatal and infant mortality as well as the children well-being. A genuine national leadership is essential for this purpose. This requires the pooling of scarce resources in the name of flagship health programs, this means directed towards a common vision beneficial to all stakeholders. Thus: 1) the Expanded Program of Immunization would see routine vaccination coverage take off and epidemics, particularly measles, contained without mass vaccination campaigns; 2) endemic undernutrition in children numbers would decrease both in areas of political crisis and in urban settings; 3) cases of pneumonia, malaria, and diarrhea would be correctly managed at the community level; 4) HIV infection would be better controlled and consequently tuberculosis in children; 5) pregnant and/or laboring women would have better follow up according to the IMNCI approach, for early detection and better management of risk factors of obstetric and neonatal emergencies; 6) newborn monitoring modalities would be known and their management predicted in case of illness. Such are the accomplishments of IMNCI, which thus represents a real opportunity for the Cameroonian health system.

### **Conclusion**

It is unthinkable and unacceptable that IMCI suffers from a lack of interest, and it should under no circumstances be judged as a failure, without the Government having mobilized its own resources to foster its renewal, and especially to ensure the survival and full potential of children, the guarantee of the nation's development. There is a need to resize IMNCI within a broader system of public primary health care services within the Family Health Department. 🌱

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