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INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI)

Integrated management of childhood illness (IMCI) is a strategy developed by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). Introduced in 1996 as the principal strategy for improving child health, it targets children under 5 years of age, focusing care on their health status rather than the diseases that occasionally strike them. IMCI thus reduces missed opportunities for the early detection and treatment of illnesses that, while not the main reason for consulting the health services, can escape the notice of health workers, with the consequent risk of worsening and leading to complications. The care provided through IMCI, moreover, includes a strong disease prevention and health promotion component, whose benefits include broader vaccination coverage and better knowledge and practices with respect to the care and treatment of children under 5 in the home, thus contributing to healthy growth and development.

Implementing IMCI requires the participation of the health services and community alike, through three components. The first is designed to improve the performance of health workers in the prevention and treatment of childhood illness; the second, to upgrade the health services so that they offer appropriate quality care; and the third, to improve family and community practices in caring for children.

This document summarizes the progress made through IMCI in the Hemisphere, the interagency coordination developed in its support (involving bilateral and international agencies, foundations, and nongovernmental organizations), and the mobilization achieved at the local level with broad community participation. It also describes the evidence obtained about the benefits of IMCI and the main obstacles to expanding its implementation and ensuring that these benefits reach every child in the Hemisphere. Given the progress made and the obstacles to be overcome, it is proposed that the most appropriate mechanisms for strengthening the implementation of IMCI and expanding its coverage among the population be determined and discussed.

This document is submitted to the 130th Session of the Executive Committee with the following objectives: a) to request ideas and recommendations for the Bureau and the countries on how to overcome the obstacles that arise and strengthen the implementation and expansion of IMCI; and (b) to identify mechanisms that the Bureau and the countries can use to expand the mobilization of resources and secure universal access by children to the benefits of IMCI.

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Implementation of Integrated Management of Childhood Illness in the Americas: Progress and Challenges

1. Introduction

Improving child health requires not only promoting living conditions favorable to children's growth and development, but guaranteeing that all boys and girls benefit from the available prevention and treatment measures—measures that will keep them free of many illnesses and prevent such illnesses from becoming serious when they do strike, thus averting a potentially fatal outcome. Integrated Management of Childhood Illness (IMCI) is a strategy that includes all of these measures. It can be used by health workers and others responsible for the care of children under 5 years of age, including parents. It offers the necessary knowledge and skills for the sequential and integrated assessment of children's health status and, thus, the detection of the most common illnesses or health problems, as determined by the epidemiological profile in each locality. IMCI provides clear instructions on how to classify the illnesses and health problems discovered in the assessment and outlines the treatment that should be administered for each of them. It also contains indications for monitoring the progress of the treatment, identifying the need for preventive measures, and informing and educating parents about how to prevent disease and promote the health of their children.

In light of this, IMCI is currently considered the most efficient strategy for reducing the burden of disease and disability in the population and contributing to healthy growth and development during the first 5 years of life.

2. Current Situation

The IMCI strategy was developed jointly by the World Health Organization and the United Nations Children's Fund (UNICEF) and targets a group of infectious diseases that are still responsible for 20% to 30% of mortality in children under 5, and in some countries of the Hemisphere, for as much as 50%. IMCI also includes health promotion contents that are specially designed to improve the care and feeding of children during their first 5 years of life.

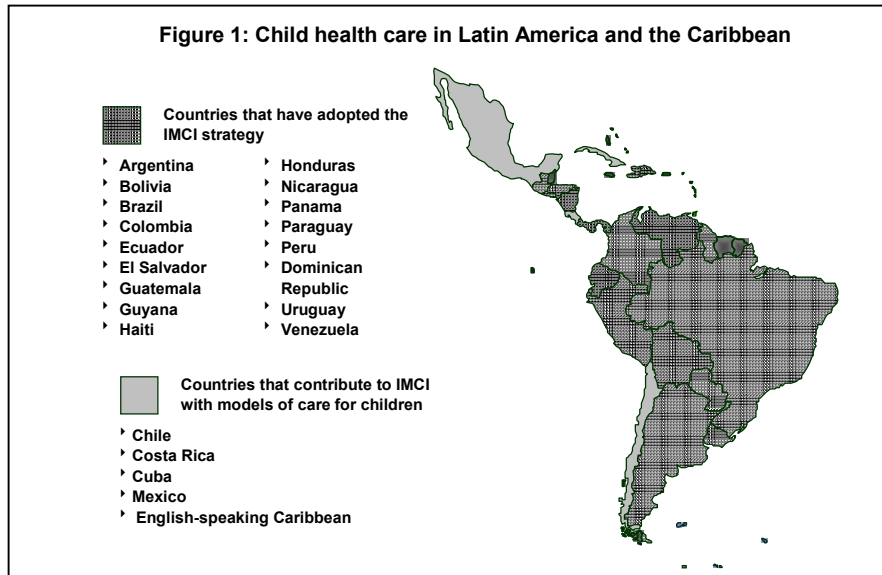
In 1996, PAHO officially introduced the IMCI strategy to the countries of the Hemisphere and promoted its implementation, given its potential for reducing mortality and morbidity in children under 5 and the contribution it could make to ensuring adequate health care for children, not only in the health services but in the home and community as well.

In the years that followed, many countries gradually incorporated the IMCI strategy into their maternal and child health activities. Their content and the process itself

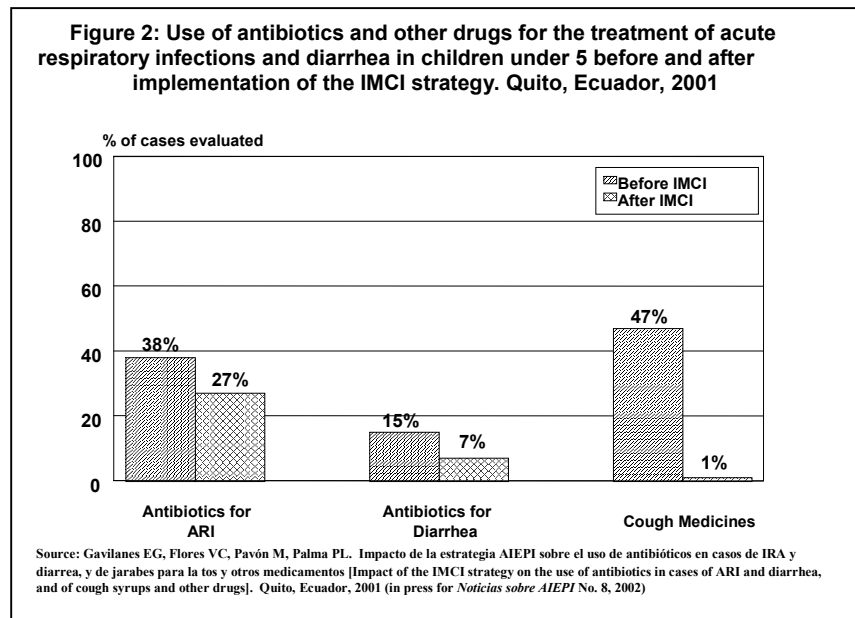
were enriched with the experience gained in the countries of the Region during the implementation of other control strategies for the illnesses that affect infants and children, and with the design and application of integrated care modalities in first level services.

In 1999, the 41st Directing Council of PAHO adopted Resolution CD41.R5, urging the Member States to adopt and expand implementation of the strategy and requesting the active participation of the Director in this process. Late that year, PAHO launched the "Healthy Children: Goal 2002 Initiative", aimed at preventing 100,000 deaths in children under 5 during the period 1999-2002 and offering the entire population access to the IMCI strategy, especially the most vulnerable groups.

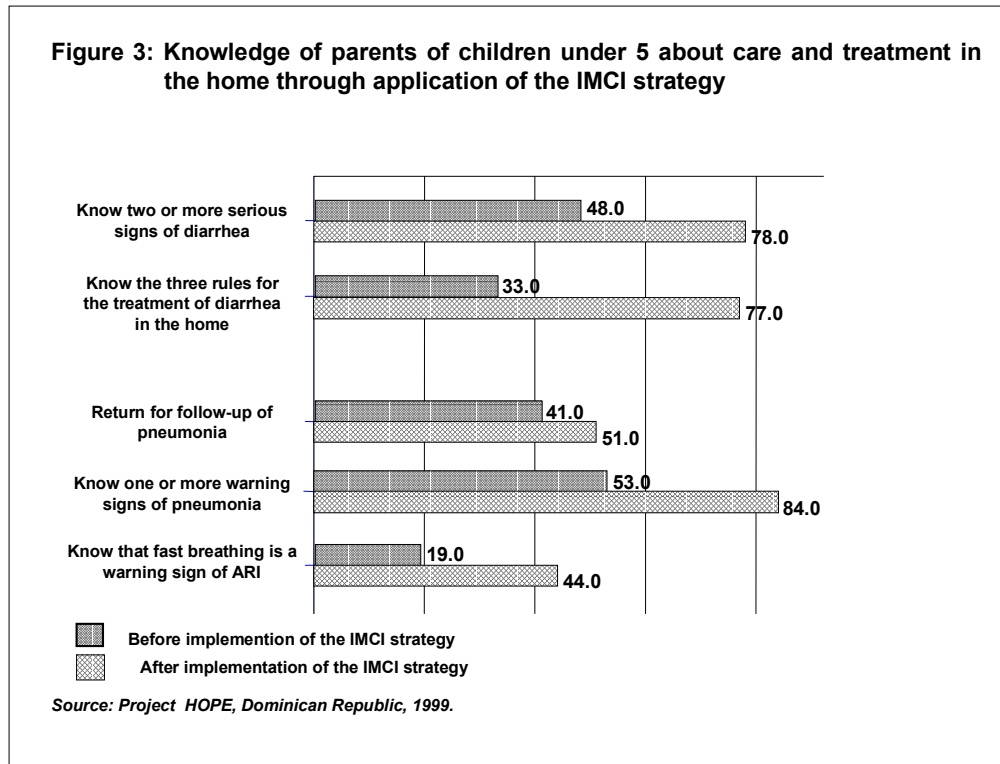
By late 2001, 17 Latin American and Caribbean countries had adopted and implemented the IMCI strategy. Other countries also participated in this process, contributing models of care that were already in execution (Figure 1). As part of the design and addition of new components, since 2001 work has been under way with the rest of the countries of the Region to learn what contribution IMCI can make to existing activities for the care and treatment of infants and children.



The evaluations conducted have revealed significant improvements in the quality of care provided to children under 5 by staff trained in the IMCI strategy (Figure 2), especially in terms of reducing the unnecessary use of antibiotics and using first-line antibiotics—practices that help to rationalize the use of these drugs and contain bacterial resistance. A reduction has also been observed in the use of cough medicines for the treatment of childhood respiratory illnesses—drugs that are unnecessary and potentially harmful.

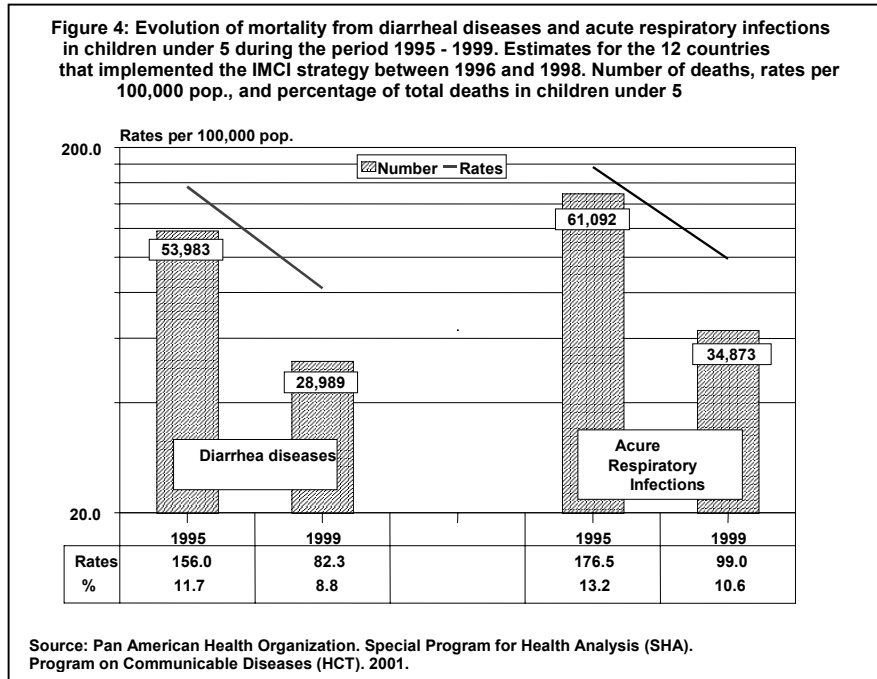


These evaluations have also showed that the IMCI strategy is effective in improving the knowledge and practices of parents and families to promote disease prevention and health promotion, early consultation when illness strikes, and compliance with the treatments prescribed (Figure 3).



Evaluation of the mortality figures in children under 5 have also revealed a significant impact in the form of a sharp decline in the number of deaths in that age group and among such deaths, those from the causes targeted by the IMCI strategy. In the first year of the "Healthy Children: Goal 2002 Initiative", the number of deaths in children under 5 fell by more than 30,000, a decline of more than 6% annually. Most of this decline is attributable to the sharp drop in mortality from the causes targeted by the IMCI strategy, which fell by more than 15% annually.

Monitoring of the mortality from diarrheal diseases and pneumonia, which are responsible for most of the deaths from the illnesses targeted by the IMCI strategy, has also revealed a decline in the number, rate, and proportion of deaths from these causes in children under 5. In the 12 countries that implemented IMCI between 1996 and 1998, which account for two-thirds of the under-5 population in Latin America and the Caribbean, mortality from diarrhea dropped by 47% between 1995 and 1999, and mortality from ARI by 44% (Figure 4). Both declines were steeper than the regional decline, which was 39% in each case.



This progress was the fruit of a major effort and broad coordination at the regional, subregional, and country levels. Efficient coordination was achieved in the countries between the ministries of health and other governmental and nongovernmental entities working to improve child health; this made it possible to promote implementation of the IMCI strategy through the health services and other public and private institutions, NGOs, and community organizations.

Despite this progress, however, the demonstrable benefits of the IMCI strategy in preventing disease and promoting healthy lifestyles have yet to reach a significant proportion of children under 5 in the Americas. Many families are still without access to trained personnel and health services in a position to apply the strategy and do not receive the information offered by IMCI to improve growth and development during the initial years of life.

Overcoming the lack of equity posed by this situation in terms of access to knowledge and practices critical for healthy child growth and development requires a united effort to ensure effective implementation and expansion of the strategy in all the countries of the Region. PAHO can play a decisive role here by assisting the countries in successfully implementing IMCI and setting up mechanisms to facilitate mobilization of the available resources at the regional and national levels to guarantee universal access to the strategy.

2.1 *Adoption of the IMCI Strategy and Progress of the "Healthy Children: Goal 2002 Initiative"*

By late 2001, 17 Latin American and Caribbean countries had adopted the IMCI strategy. These countries have 52% of the under-5 population of the Hemisphere but account for 75% of the annual deaths in this age group.

Countries that have adopted IMCI have not done so only because of the high mortality from infectious diseases in children under 5, which is currently the basic focus of the strategy. Some have adopted IMCI because of its capacity to improve the quality of care (i.e., fewer missed opportunities for detecting and treating health problems and instituting preventive measures), ensure better utilization of resources and diagnostic and treatment technologies, and offer parents more and better information on the care and treatment of their children.

All of the countries adopted the "Healthy Children: Goal 2002 Initiative". Ten of them launched the initiative with national and local events to encourage institutional and community participation and thereby speed up the decline in mortality through the implementation of the IMCI strategy.

Bringing IMCI to the rest of the countries can be an important step toward improving the quality of health care for children, especially if the strategy is applied by personnel and health services that attend to population groups with no health care coverage or whose access to health care is limited.

Implementation of IMCI in all the countries can also help to strengthen and improve the knowledge and key practices promoted by WHO and UNICEF for healthy growth and development during infancy and childhood (Table 1). These practices, for parents and others responsible for the health care of children under 5 (workers in day-care centers and community kitchens, teachers, mother surrogates), will better enable families to foster the healthier growth and development of their children during the first years of life.

**Table 1: 16 Key Family Practices for Healthy Growth and Development.
WHO and UNICEF**

For physical growth and mental development
1. Breast-feed infants exclusively six months. (Mothers who are HIV+ should be counseled on other options for feeding their babies, taking into account WHO/UNICEF/ UNAIDS policy and recommendations on HIV and infant feeding).
2. Starting at 6 months, feed children freshly prepared, energy and nutrient-rich complementary foods, while continuing to breast-feed for up to two years or longer.
3. Provide children with adequate amounts of micronutrients (vitamin A and iron, in particular), either in their diet or through supplements.
4. Promote children's mental and social development by being responsive to the child's need for care, and stimulating the child through talking, playing, and other appropriate physical and affective interactions.
For disease prevention
5. On the scheduled dates, take children for the full course of immunizations (BCG, DPT, OPV and measles) before their first birthday.
6. Dispose of feces (including children's feces) safely, and wash hands with soap and water after defecation and before preparing meals and feeding children.
7. In malaria-endemic areas, protect children by ensuring that they sleep under recommended insecticide-treated mosquito nets.
8. Adopt and sustain appropriate behavior for the prevention and the care of people with HIV/AIDS, especially orphans.
For appropriate home care
9. Continue to feed and offer more fluids to children, especially breast-milk, when they are sick.
10. Give sick children appropriate home treatment for infections.
11. Prevent and provide appropriate treatment for child injuries.
12. Prevent child abuse, recognize it has occurred, and take appropriate action.
13. Ensure that men actively participate in providing childcare and that they are involved in reproductive health initiatives.
For seeking care
14. Recognize when sick children need treatment outside the home and take them for health care to the appropriate providers.
15. Follow health workers' recommendations regarding treatment, follow-up, and referral.
16. Ensure that every pregnant woman receives adequate prenatal care, which consists of a minimum of four prenatal visits with an appropriate health service provider and the recommended doses of tetanus toxoid. Mothers need family and community support in seeking appropriate care, especially at the time of delivery and during the postpartum/lactation period.

Furthermore, the gradual addition of new contents in the prevention, treatment, and health promotion is making the strategy increasingly compatible with the epidemiological situation of countries with lower mortality figures. For this reason, since 2001 work has been under way with the rest of the countries of the Hemisphere to determine what benefits adapting IMCI and its new components can offer to guarantee that all children, particularly the most vulnerable groups, have access to efficient, adequate quality health care, thus contributing to the reduction of morbidity and mortality in infants and children.

2.2 Incorporating the IMCI Strategy into the Basic Health Measures Accessible to All the Population

The way and the extent to which the IMCI strategy is incorporated varies from country to country. In some countries, the strategy was adopted by a resolution making it the official health care policy for children. In others, the IMCI strategy was added to the existing maternal and child programs, thus superseding strategies for the control of specific illnesses, such as acute diarrheal diseases or acute respiratory infections in children.

While some countries are moving forward with the implementation of IMCI through the social security system and its integration into health sector reform, these are generally special initiatives, not an organic plan to guarantee that the strategy actually becomes a basic health service for all children under 5.

2.3 Planning and Setting Goals to Achieve Universal Access to IMCI through the Health Services and in the Community

All the countries that adopted the IMCI strategy drew up plans to target its implementation to the most vulnerable areas and population groups, using infant mortality levels as the criterion. As part of these plans, they set goals compatible with the "Healthy Children: Goal 2002 Initiative", making a commitment to speed up the decline in mortality among children under 5 from the causes targeted by IMCI and reduce the number of deaths, in keeping with the goals established in the initiative.

In implementing the plans, significant progress was made in training health services personnel to apply the procedures outlined for the care of children under 5. The number of trained staff was increased, thanks to a regional, national, and local training mechanism, which has already trained more than 30,000 people in the application of IMCI.

Although mechanisms are in place to monitor the progress and results of implementing IMCI, some countries are still experiencing difficulties in providing information that is timely and extensive enough to measure the impact of the strategy. This is particularly important for mortality in children under 5, since a reduction in this area is the primary objective of the strategy.

Monitoring of the "Healthy Children: Goal 2002 Initiative" revealed significant potential for improving this situation, together with a willingness to set up efficient coordination mechanisms among the different sectors involved in the generation, collection, and analysis of the pertinent mortality data.

In the past two years, PAHO/WHO and UNICEF, in turn, have proposed a series of 16 key family practices for healthy growth and development, which constitute the core of the community component of the IMCI strategy (Table 1). Promoting these practices and their adoption by families and communities can lead to a significant decline in current incidence and mortality rates, while helping children to grow healthily and receive the stimulation they need for better development.

For this reason, work is under way to design materials and mobilize the mass media to expand the use of IMCI throughout the Hemisphere. A social communicator is also being added to the regional IMCI team to help multiply and diversify these efforts and mobilize resources. This will ensure greater dissemination and promotion of the 16 key family practices for child growth and development.

These actions can serve as backing for the increased community mobilization that the countries are promoting around the IMCI strategy through projects that target the community component of IMCI—for example, PAHO's projects with the American Red Cross (ARC) and the United Nations Foundation (UNF). These projects have fostered close coordination among communities, government health services, and nongovernmental organizations operating in the local sphere, encouraging them to work together in the preparation, implementation, monitoring, and evaluation of plans to make the IMCI strategy accessible to the most vulnerable groups and thus prevent disease, promote health, and facilitate access to adequate quality care.

2.4 *Economic Support and Mobilization of Resources for IMCI*

The launch of the "Healthy Children: Goal 2002 Initiative" permitted the mobilization of resources to support IMCI activities at the regional level, particularly those of the community component, aimed at improving knowledge and practices for the care of children in the home. At the country level, there was better coordination with nongovernmental organizations and agencies to promote the implementation of the IMCI strategy.

Projects are currently under way with support from the U.S. Agency for International Development (USAID), Basic Support for Institutionalizing Child Survival (BASICS II), the ARC, the UNF, the Government of the Netherlands, and numerous nongovernmental organizations, especially in the countries. Some projects are in an advanced stage of the approval process—for example, the joint PAHO/Canadian International Development Agency (CIDA) proposal, scheduled to begin in 2002.

Notwithstanding, sufficient mobilization has not yet been achieved to expand implementation of the strategy fast enough to guarantee universal access by the most disadvantaged population groups or to support and sustain monitoring and evaluation mechanisms that will ensure effective implementation of IMCI and measure its results. This is especially true since some of the projects, such as the one with USAID and BASICS are about to conclude, though they may be extended, or have already concluded—for example, the project supported by the Spanish Agency for International Cooperation (AECI).

In order to achieve this, greater regional and national resources will be needed, as well as external financing to ensure the continuity of existing projects and continue to strengthen and expand the implementation of IMCI.

2.5 *Introduction of IMCI in the Training of Health Personnel*

The IMCI strategy is already being used in pediatrics training in around 100 of the 350 medical schools in Latin America and the Caribbean. It is also being used in the Region's nursing schools, which already number about 60. This has been fostered by the coordination provided by the regional level to get these institutions involved in the adaptation of the strategy and the training of facilitators.

The experience in many countries indicates that effectively incorporating the IMCI into academic programs could help to ensure that all students in medicine, nursing, and other health professions graduate with the ability to apply the IMCI strategy in health care delivery. It would also ensure that the thousands of students doing compulsory social

service in the last year of their program bring the benefits of the strategy to the populations they serve, in terms of preventing and treating illness and improving knowledge and information about best practice in promoting child health.

However, most medical and nursing schools, as well as other academic institutions that train health workers, do not guarantee that their graduates will be able to apply the IMCI strategy in the care of children under 5. This issue is especially important as it relates to students beginning their compulsory social service, since they work in health services that cover at-risk populations that could benefit from the potential impact of the strategy on mortality, morbidity, and the quality of care.

2.6 Adapting the IMCI Strategy to Different Epidemiological and Operational Realities

Adapting the IMCI strategy was part of the implementation process. Its purpose was not only to fine-tune the basic contents but introduce additional contents for the prevention and treatment of other prevalent illnesses in the epidemiological profile of the country and the Region. The preparation and incorporation of these contents took place within the countries, between the countries, and at the regional level.

As a result of this process, components were added for the control of dengue, respiratory ailments (illnesses of the throat, chronic obstructive pulmonary diseases), and abuse. The design of contents to control oral health problems and neonatal disorders and promote early stimulation and development is being finalized.

These new contents boost IMCI's potential for improving the health status of children—on the one hand, by reducing mortality and morbidity with the inclusion of other common causes of death before age 5, such as perinatal disorders and accidents; and on the other, by improving the conditions for growth and development, thanks to its content in areas such as early stimulation, oral health promotion, and accident and abuse prevention.

3. Proposed Actions

The progress made and results obtained demonstrate IMCI's potential for improving the health status of children. However, all the countries' populations do not have access to IMCI. This is particularly serious in the case of highly vulnerable populations that could benefit from the strategy's potential to reduce mortality and morbidity and improve growth and development in infants and children.

The actions listed below can assist in overcoming this problem and ensure that all children under 5 in the Region of the Americas can enjoy the benefits of the IMCI strategy in terms of better health care.

- *Effective incorporation of the IMCI strategy into the regulatory frameworks of the countries and systems for monitoring its implementation is fundamental for it to become the universal, basic service for children's health care.* Through this decision, the countries can make progress toward guaranteeing that all children under 5 have access to the benefits of the IMCI strategy, making its compulsory use the minimum quality of care offered by institutional and community health workers in public health, social security, and private health services.
- *Making training in the IMCI strategy part of university and graduate programs in the health professions will guarantee that investments in the education of these personnel cover the health needs of the population.* This will also lead to more efficient resource use, for it will keep ministries of health from having to invest in graduate training further down the line to ensure that professionals meet the performance standards set for them in the health services. Including IMCI in university education will also enable students fulfilling their compulsory social service requirement in the health services during the final year of training to extend the benefits of IMCI, in terms of improving child health, to the people they serve.
- *Preparation and implementation of special plans to promote the 16 key family practices for healthy growth and development proposed under the community component of the IMCI strategy through all communication channels.* Furthermore, utilization of these key practices in intersectoral coordination on behalf of children, particularly at the local level and within the framework of community-based projects for the implementation of the IMCI strategy. This will enable the countries to take advantage of all areas involved in social development to ensure their active participation in improving the ability of families and communities to provide better care for children at the local, intermediate, and national levels. It will also promote more efficient use of the available resources for health and development.
- *Establishment of active, coordinated mechanisms to ensure timely and sufficiently extensive information on deaths in children under 5; with the existing resources, these mechanisms can improve the countries' capacity to utilize information as a tool for measuring progress, identifying problems, and setting priorities.* These mechanisms can reinforce the current progress in gathering information to monitor the "Healthy Children: Goal 2002 Initiative" and can be complemented

with national and local studies that will help avert deaths preventable with the application of the IMCI strategy.

- *Speedier addition of new contents for the prevention and control of other illnesses and health problems in children under 5, consistent with the epidemiological profile of the Region of the Americas.* These contents specifically include the control of problems associated with the perinatal period, the cause of more than one-third of all deaths in children under 1 year; the prevention and control of accidents, the leading cause of mortality in children over 1 year; and the prevention and control of obstructive pulmonary disorders, abuse, violence, and developmental problems in children through early stimulation, the detection of developmental delays, and the promotion of oral health.
- *The mobilization of extrabudgetary resources for PAHO/WHO to continue its support for expanding the IMCI strategy in terms of population coverage, the simultaneous strengthening of its three components (health workers, health services, and the community), and its contents in prevention, treatment, and health promotion in children.* It is particularly necessary to ensure the continuity of external resources for special projects financed by bilateral cooperation agencies (such as those with USAID or the Spanish Agency for International Cooperation), which have facilitated rapid expansion of the strategy and progress toward meeting the established goal, in addition to accelerating the decline in mortality among children under 5. It is also essential to promote the participation of other agencies, such as CIDA, so that their efforts can be joined to the expansion of the IMCI strategy. This experience has the potential for expansion to the bilateral external cooperation agencies of other countries of the world.

4. Financial Consequences

The Regional IMCI unit has regular and over-the-ceiling funds totaling US\$350,000 annually. It has also received extrabudgetary resources from WHO and the bilateral agencies of the Governments of the United States (USAID), Spain (AECI), and the Netherlands, which finance special plans and activities at the regional and country levels. In 2001, funds were received for a joint project with the ARC to strengthen the community component in regional activities and in 10 countries. In 2002, funds are expected from CIDA and the UNF for specific projects to expand and strengthen the implementation of IMCI.

However, there will be significant reductions in extrabudgetary resources in 2002 as a result of cutbacks in WHO funding, the conclusion of the five-year project with USAID, and the end of the support from AECI.

In order to continue to expand and strengthen the implementation of the IMCI strategy, contribute to the reduction of mortality, and improve the health status of children, it will be necessary to redouble efforts to maintain the existing resources from WHO and the USAID and AECI projects; to support the approval of projects submitted to CIDA and the UNF; and to search for potential new sources of financing.

5. Key Areas for Deliberation

Since its launch in 1996, IMCI has enjoyed vast acceptance, chiefly due to the change in approach that it promotes in the care of children under 5, which focuses on the health status of children instead of the illnesses that occasionally strike them. IMCI has proven an effective tool for the early detection and treatment of illness, and this has impacted serious morbidity and mortality. IMCI has also made it possible to take advantage of all the opportunities for disease prevention and health promotion, providing better quality care in the health services and the home.

The addition of new components to prevent and control childhood illness, resulting in lower infant mortality, and the strengthening of health promotion contents have boosted IMCI's potential for guaranteeing a basic standard of care accessible to all children in the Region of the Americas.

Nevertheless, the potential benefits of the IMCI strategy have yet to reach all sectors of the population. Thus, other steps must be taken to expand and improve the access of all children to IMCI, especially those in the most vulnerable groups.

The following areas are therefore proposed for discussion and deliberation.

5.1 *Incorporation of IMCI as a Universal Basic Health Service for Children and as Basic Content in University and Graduate Training Programs*

IMCI brings together the most up-to-date knowledge in pediatrics to guarantee proper assessment and treatment of the most common childhood illnesses and health problems. It includes, moreover, the basic measures for disease prevention that should protect all boys and girls during their first 5 years of life and provides the most important knowledge and practices that parents should apply to safeguard the healthy growth and development of their children. Thus, IMCI constitutes a basic standard of care that should be accessible to all children under 5, and to which other measures can be added, depending on the epidemiological situation or operating capacity of the health services, families, and the community.

In this regard, what are the obstacles that still prevent IMCI from being used effectively in many health services or from being included as basic content in university and graduate programs for health workers, and what actions and steps can PAHO take with the countries to overcome them?

5.2 *Promotion of the Key Family Practices for Healthy Growth and Development Proposed in the IMCI Strategy*

A basic set of knowledge and practices for application by those responsible for the care of children will ensure that children grow and develop in a healthy manner, do not get sick, and receive timely and effective care when they do. These practices do not require sophisticated technologies or resources beyond the reach of most families. However, many families lack the necessary information about them and do not receive help in acquiring the skills for their effective application in the home. IMCI has synthesized the knowledge and key practices for healthy growth and development into a single strategy. However, this information must reach all families—first and foremost those belonging to the most vulnerable population groups.

How can we ensure the widest and fastest dissemination and promotion of the 16 key family practices for healthy child growth and development, and what specific action can PAHO and the countries take to contribute to this?

5.3 *Expansion and Monitoring of the IMCI Strategy*

The varied epidemiological situations in the countries of the Hemisphere and IMCI's potential as the entry point for improving the health status of children have created the need to broaden the basic contents of the strategy to include activities for the prevention and treatment of other health problems. However, moving forward with this process requires clear identification of the magnitude of the new problems that must be addressed and adequate monitoring of IMCI's impact on child mortality and morbidity. However, the information needed for monitoring and evaluation, especially mortality data, is not always timely nor does it include the appropriate coverage.

Within this context, how can PAHO, working with the countries, optimize the use of available resources to improve the breadth and timeliness of the key information for monitoring IMCI mortality data? Furthermore, in what order should new contents for the prevention and treatment of other illnesses be added to IMCI to heighten its impact on child mortality and morbidity?

5.4 *Economic Support and Mobilization of Resources for IMCI*

Strengthening the implementation of IMCI, expanding its coverage, improving impact assessment mechanisms, and broadening its contents are priority lines of action for sustaining and accelerating the decline in mortality and morbidity and contributing to healthy children. However, the resources available for this at the regional and country levels are limited. How can PAHO augment the existing resources to support IMCI at the regional and country levels?

6. Action by the Executive Committee

Based on the information presented, the Executive Committee is requested to:

- Study the action that PAHO, together with the countries, can take to ensure that IMCI is successfully adopted as a basic standard of health care for children and included in university and graduate programs leading to a career in health.
- Recommend action that can be taken at the regional and national levels to ensure the broadest and fastest dissemination and promotion of the 16 key family practices for healthy growth and development.
- Suggest to the Bureau the best way to strengthen the monitoring and evaluation component of IMCI, gradually expanding contents for the prevention and control of other illnesses, and mobilizing resources for its implementation.