

Funding Arrangements for Integrated Management of Neonatal and Childhood Illness (IMNCI)

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Abstract: The national level training of the faculty of Medical Colleges of different States need not provide for budget in their NRHM/RCH-II Programme Implementation Plans (PIPs) as the funding for this training will be entirely provided by the Government of India. This will include all costs such as TA/DA, stay and other training expenses. Child health has remained an essential component of most of the national health programs in India from Expanded Program of Immunization (EPI) in 1974 to the most recent national rural health mission. In India, common illness in children under 3 years of age include Fever (27%), Acute respiratory infections (17%), Diarrhoea (13%), Malnutrition (43%) and after in combination.

Keywords: IMNCI, RCH, PIPs, Neonatal, Mortality.

Date of Submission: 30-12-2018

Date of acceptance: 14-01-2019

I. Introduction

State Level Training (At The Medical Colleges Identified As Training Centres)

The States need to project their funding requirements for the following in their NRHM/RCH-II-PIPs: Equipments for imparting training such as One Computer with in-built CD RW/ROM, One LCD Projector with display screen. Other miscellaneous training/ teaching accessories: TA/DA and honorarium to the trainees and trainers as per RCH norms, Vehicle hiring for field visits for trainees as per State Government norms.

District Level Training

- a) At District Training Cell (in the District Hospital): The States need to project their funding requirements for the following in their NRHM/RCH-II-PIPs: Equipments for imparting training such as: One Computer with in-built CD RW/ROM, One LCD Projector with display screen. Other miscellaneous training/ teaching accessories. TA/DA and honorarium to the trainees and trainers as per RCH norms, Vehicle hiring for field visits for trainees as per State Government norms.
- b) At other Training Centres within the District (Maximum two in identified CHCs/PHCs): The States need to project their funding requirements for the following in their NRHM/RCH-II-PIPs: Equipments for imparting training such as: One television (which is CD player compatible), One CD player, Other miscellaneous training/ teaching accessories, TA/DA and honorarium to the trainees and trainers as per RCH norms, Vehicle hiring for field visits for trainees as per State Government norms.

Translation, Printing And Supply Of Training Material

The modules, charts, booklets, videos and facilitators guides will be made available to the States for facilitating training under IMNCI. These will need to be translated and printed in local languages depending on the needs of each State. The funding requirements for the same may be projected in the State NRHM/RCH-II-PIPs

Field-Level Monitoring Support, Follow Up And Coordination

A reasonable budget may be indicated in NRHM/RCH-II PIPs as institutional charges for monitoring and follow up visits/meetings, coordination and other related activities for successful implementation of IMNCI trainings.

Mortality Rate

In 2016, India's infant mortality rate was 44 per 1,000 live .

In 2017, sex-specific under-five mortality rate was 39 in 1,000 for male and 40 in 1,000 for female.

II. Need For Integrated Management

Many well-known interventions like universal immunization, essential newborn care, and exclusive breastfeeding during first 6 months of life, appropriate complementary feeding, oral rehydration therapy, and timely and appropriate use of antibiotics in pneumonia have proved to be effective. Sick children often present with overlapping signs and symptoms common to different illnesses and often suffer from more than one illness which may necessitate different treatments. Another reason for integrated approach is the need for incorporating preventive strategies such as immunization and nutrition along with curative care.

III. Integrated Management Of Childhood Illness (IMCI)

During mid-1990s, WHO, UNICEF and many other agencies responded to develop an evidence-based, syndromic approach to integrated case management of childhood illness (IMCI) that supports the rational, effective and affordable use of diagnostic tools and drugs. It is a preventive, promotive and curative strategy aimed at reducing childhood mortality and frequency severity of childhood morbidities and disabilities, and also contributing to improved growth and nutrition of under-five children. Integrated management of neonatal and childhood illness (IMNCI). 2006- IMNCI was launched in 16 states.

IV. Essential Components Of IMNCI Strategy

The IMNCI strategy includes both prevention and curative interventions that aim to improve practices in health facilities, the health system and at home. At the core of the strategy is integrated case management of the most common childhood problems with a focus on the most common causes of death.

- The strategy includes three main components.
- Improvement in the case management skill of health staff through the provision of locally-adapted guidelines on integrated management of neonatal and childhood illness and activities to promote their use.
- Improvements in the overall health system required for effective management of childhood illness.
- Improvements in family and community health practices.

V. Clinical Guidelines

The IMNCI clinical guidelines target children less than years old, the age group that bears the highest burden of morbidity and mortality. The guidelines represent an evidence-based, syndromic approach to case management that includes rational, effective and affordable use of drugs, careful and systematic assessment of common symptoms, using well-selected reliable clinical signs, helps to guide rational and effective actions.

An evidence-based syndromic approach can be used to determine,

- Health problems
- Severity of the child's condition
- Actions that can be taken to care for the child

In addition the guidelines suggest the adjustments required to manage with capacity of health system and active involvement of family members and health care practices.

VI. Principles Of Integrated Care

The IMNCI guidelines are based on the following principles.

- Routine assessment of all under five sick children for major symptoms like cough and for difficult breathers, diarrhoea, fever, rash or skin problems, convulsions, lethargy and feeding problems.
- Routine assessment of all under five sick children for nutritive and immunizations status and other potential problems.
- Use of limited number of carefully selected clinical signs, based on evidence of their sensitivity and specificity for early detection of diseases problems or complications.
- Detection of severity of sick child's condition by noting "general danger signs" like convulsions, lethargy or unconsciousness, inability to drink or breastfed, etc, for assessing the need of immediate referral to a upgraded health facility level.
- Classification, rather than specific diagnoses of child's condition, on the basis of selected clinical signs and symptoms, to identify the management actions according to universal color coded treatment chart.
- Pink-indicating urgent, referral or admission.
- Yellow-indicating provision of specific treatment at the outpatient health facility with available resources.
- Green-indicating managing the child at home.
- Use of carefully selected limited number of essential drugs and encouraging active participation of care givers in treatment and management of sick children.

VII. Institutional Arrangements

IMNCE is child health intervention to be implemented as part of NRHM/RCH-II. Training for IMNCI will therefore be part of the overall training plan under RCH-phase II.

State Level

- Appoint a nodal officer for IMNCI
- Set up a co-ordination group
- Arrange translation, printing and supply of training material
- Create pool of state level trainers
- Select priority districts for IMNCI implementation
- Monitoring, follow up and review of implementation of IMNCI
- Identify the state nodal institute for IMNCI training
- Improvement in family and community practices

District Level

Many of the institutional arrangements at the state level need to be developed at districts level, though emphasis is less on overall direction and quality control and more on the day-to-day activities to make IMNCI successful.

- Appoint district co-ordinator for IMNCI
- Act up an INCI coordination group
- Train district trainers
- Develop a detailed plan for IMNCI implementation in the district
- Ensure timely supplies and logistics, supervision and follow up
- IEC activities for improvement in family and community practices.

Training In IMNCI

- Focus on skill development skill development is critical to the implementation of IMNCI.
- Training at two levels
 - In service training for the existing staff
 - Pre service training
- Personnel to be trained: there are two types of training under IMNCI
 - Clinical skill training
 - Supervisory skill training
 - Training of trainers
 - Number to be trained
- Training institutions:
 - A) State level
 - B) District level
- Follow up trainings
- Pre service training

Union budget 2010-2011

The union budget, for the year 2010-11, was presented by the finance minister, PRANAB MUKHERJEE. This time the focus of the budget is on rural health care, with the fund allocations rising to a whopping 22,300 crores from 19,534 crores during the previous fiscal year. This escalation is in keeping with this evolving need of the growing health care industry of the country.

The finance minister also said that there are plans to carry out a national annual survey to analyze the health profiles of the populace in the rural districts.

Financial management under NRHM (Rs in crores):

year	Allocation	release	Expenditure	% release Against allocation	% expenditure against release
2005=06	212.73	245.16	159.87	115.24	65.21
2006-07	338.55	356.47	280.5	107.95	76.75
2007-08	433.16	590.67	397.06	136.36	67.22
2008-09	468.19	583.26	582.74	124.58	99.91
2009-10	471.91			0.00	
total	1924.54	1784.56	1420.18	92.73	79.58

VIII. Conclusion

The integrated management of neonatal and childhood illness (IMNCI) plays a major role in health aspect of all nations. As there was a low concordance between physician and IMCI algorithmic diagnosis of pneumonia and since very severe fatal disease is not a diagnosis made by the physicians, the IMCI algorithms have to be reined for appropriate management of these conditions.

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K. Meenakshi "Funding Arrangements for Integrated Management of Neonatal and Childhood Illness (IMNCI)" .IOSR Journal of Nursing and Health Science (IOSR-JNHS), vol. 8, no.01 , 2019, pp. 66-69.