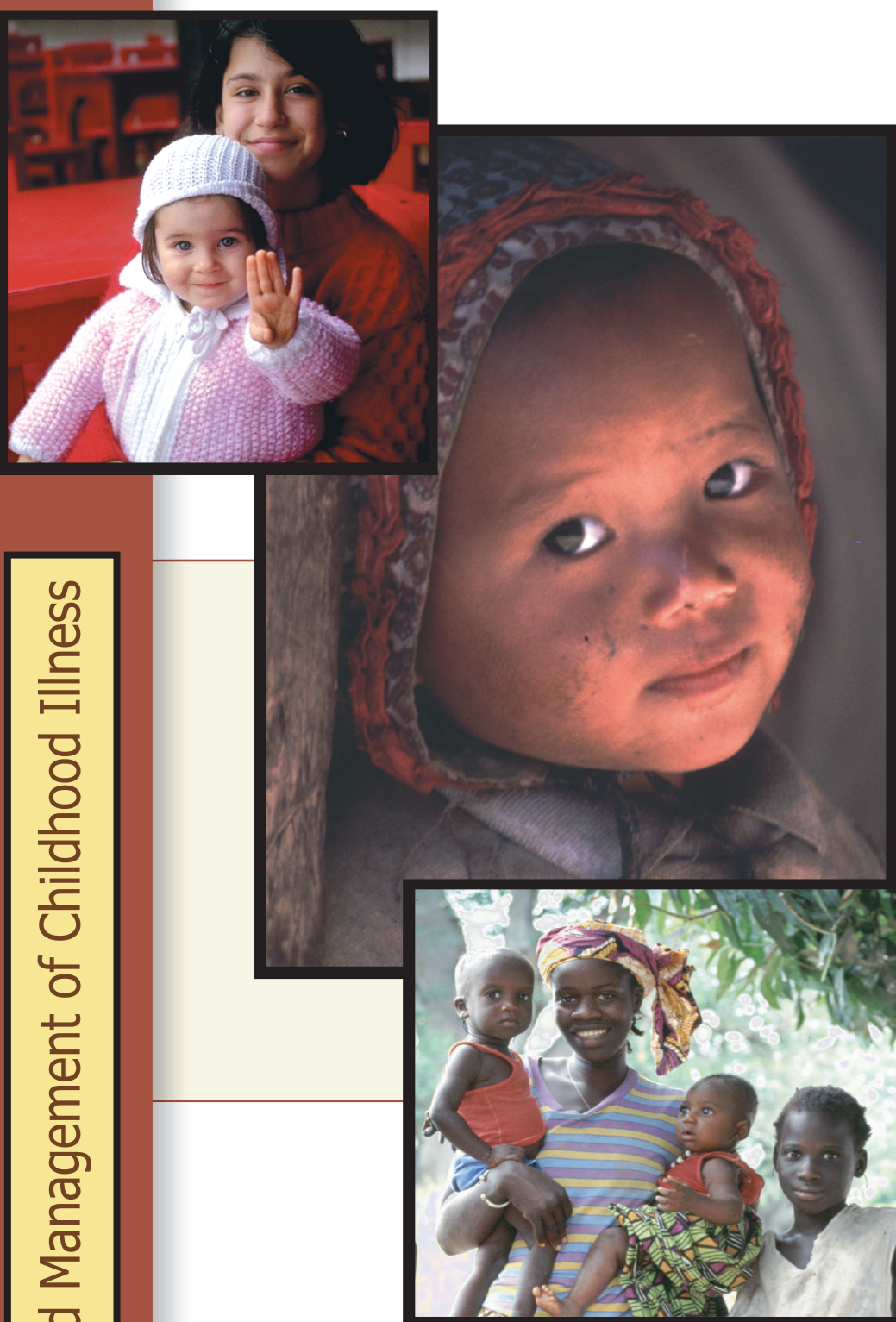


National IMCI Implementation in Peru: correlation with socioeconomic indicators

Integrated Management of Childhood Illness

Policy contributions and key messages from the Multi-Country Evaluation of IMCI



Background

- The Multi-Country Evaluation of the Integrated Management of Childhood Illness (IMCI) impact, cost and effectiveness (MCE-IMCI) involved five countries, among them Peru.
- One of the main objectives of the MCE-IMCI was to assess the extent to which access to IMCI was granted to socio-economic groups, and particularly whether it was available in the poorest regions.

Context and under-five mortality rate by departments

- Middle-income country
- 28,000 million inhabitants
- Under-five mortality rate: 47 per 1,000 live births
- IMCI implementation started in 1996
- Early scaling-up by MOH and partners
- U5MR ranges widely from less than 40 to more than 99 per 1000 live births
- High-mortality departments are more amenable to an impact of child health interventions such as IMCI

Objective and methods

- Objective: to assess the equity trends in IMCI implementation at national level in Peru
- A retrospective national study of IMCI implementation was conducted, including data on IMCI training from 1996-2000
- In addition, several socioeconomic variables were obtained from national DHS surveys and other sources (family income, female education, basic sanitation at home, human development index, and other poverty indicators)
- Bivariate correlations were run to investigate whether poorest departments had stronger IMCI implementation
- Each point in the following scatter graphs represents one of the country's 24 departments



Interpretation

- Recent reviews showed that poor children receive fewer child survival interventions than their wealthier peers
- The present results suggest that although there was a weak trend towards implementing IMCI in poor districts, there was insufficient targeting of IMCI to areas where it is mostly needed
- This may further limit the impact of IMCI on child health in Peru

Policy implications

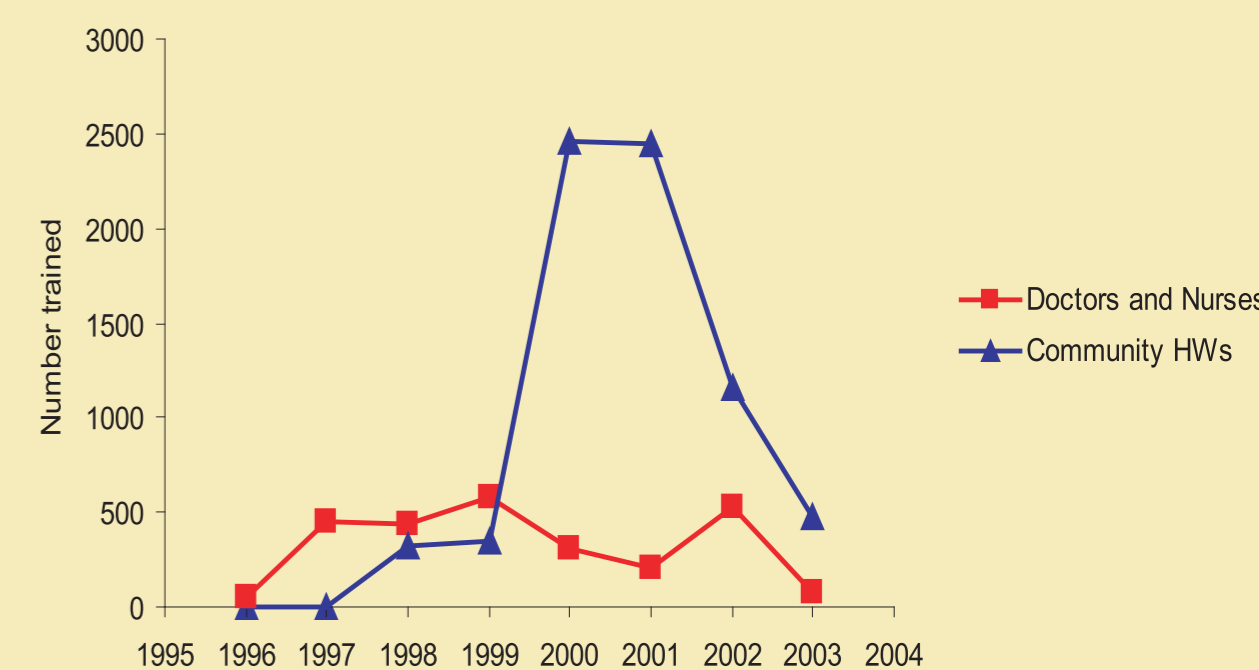
- Policy makers should target IMCI implementation to poorest regions and - within these regions - attempt to reach the poorest children
- Appropriate IMCI institutionalization and coordinated action among partners are essential for equitable scaling up of IMCI
- Child survival interventions need to be implemented first and more intensely in the poorest regions of a country if they are going to lead to a positive impact on child mortality and nutrition, and to reduce intra-national inequities

Findings

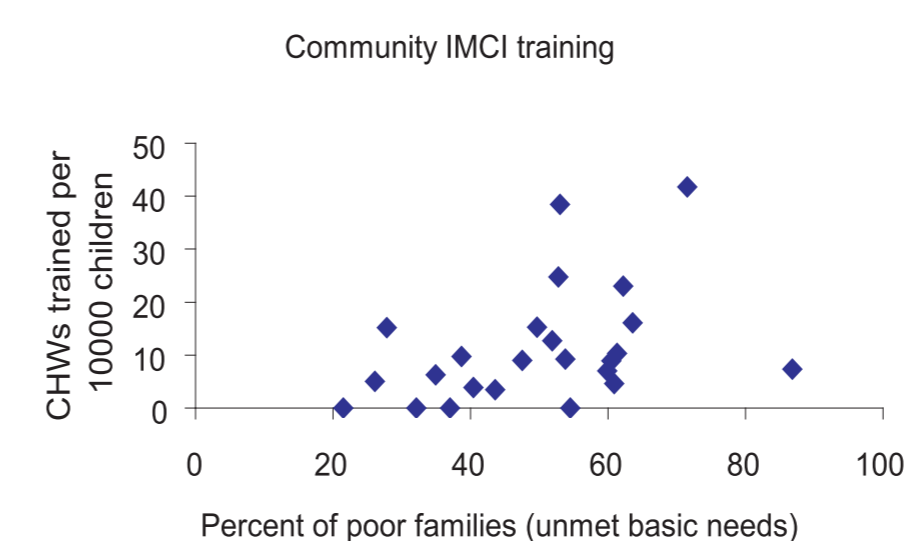
National clinical and community IMCI training coverage

The rate of clinical training peaked in 1999, then fell, with a slight increase in 2001, and fell again thereafter

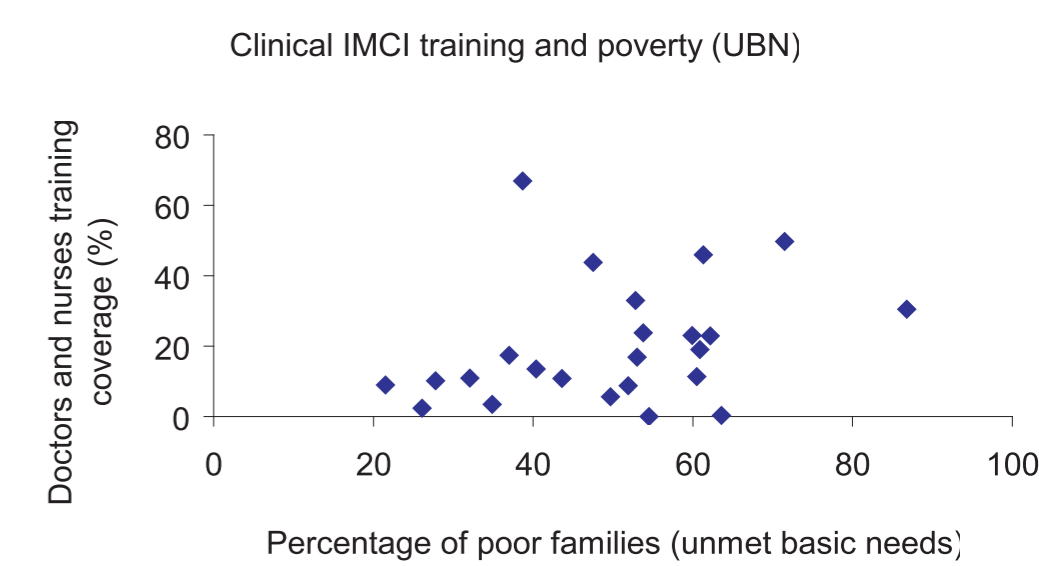
For community health workers, the rate of training increased sharply from 1999 to 2000, declining afterwards.



Poverty vs. IMCI training

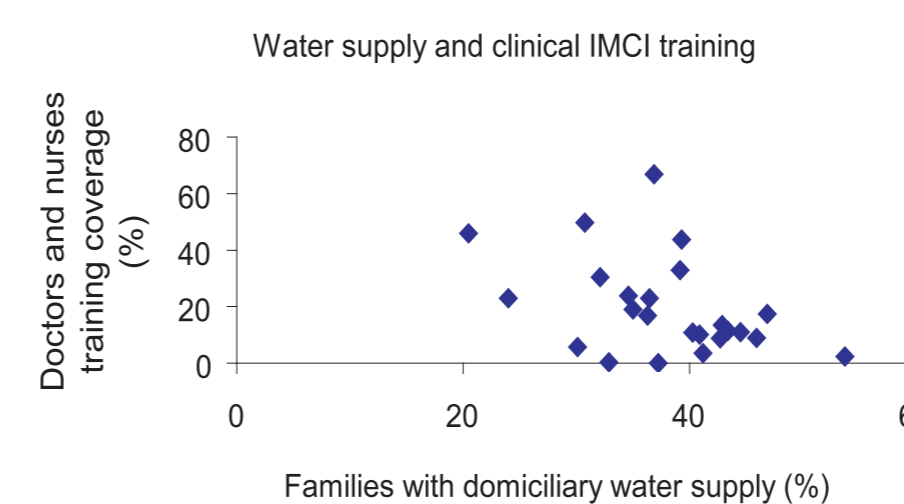


Poverty (% of families with unmet basic needs), showed a direct correlation with community IMCI training ($r=0.40$, $p=0.05$)

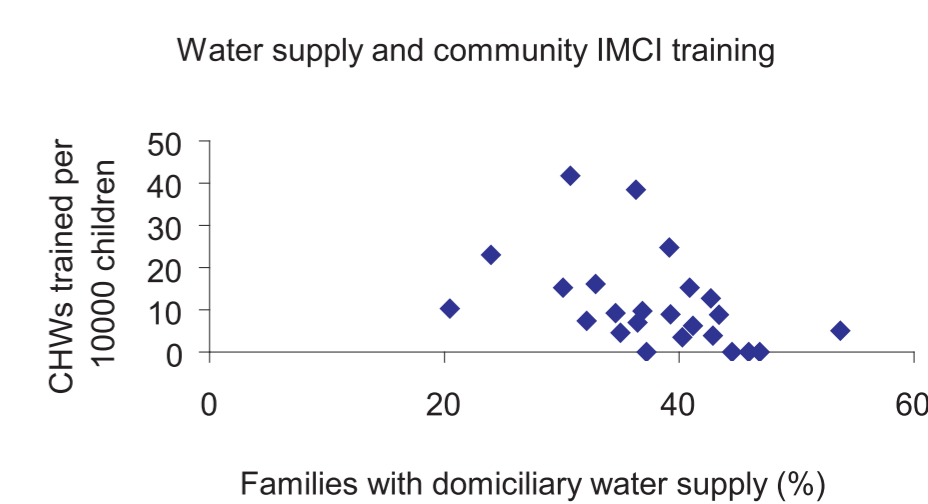


And a non-significant direct correlation with clinical IMCI training ($r=0.30$, $p=0.15$)

Household water supply vs. IMCI training

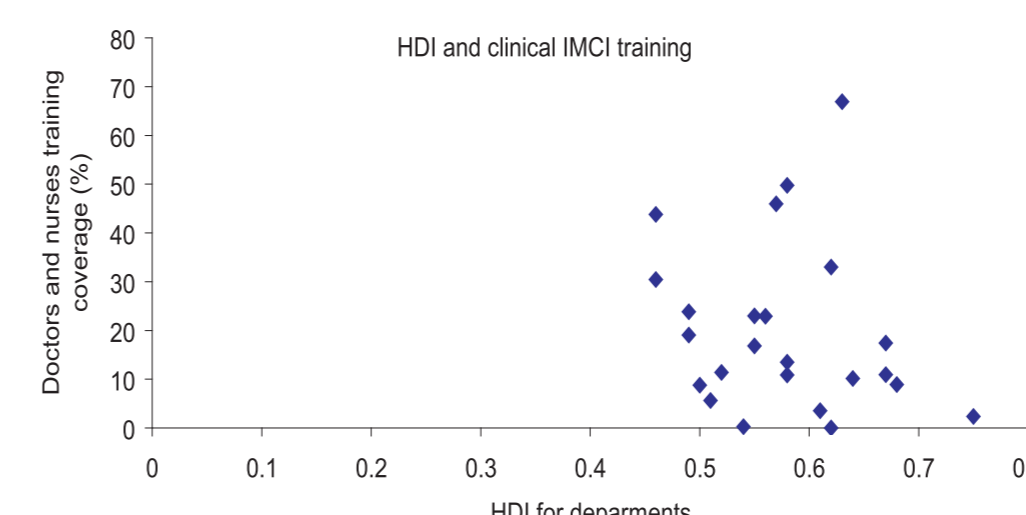


Water supply had a significant correlation with clinical training ($r=-0.43$, $p=0.04$)

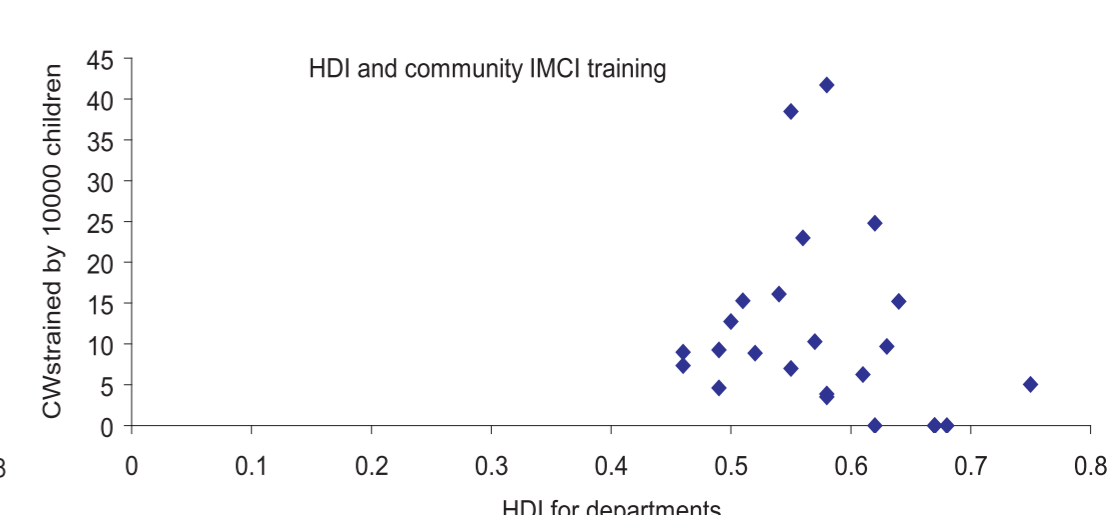


And also with community training ($r=-0.44$, $p=0.03$)

Human Development Index vs. IMCI training



With clinical training: there was a non-significant inverse correlation ($r=-0.19$, $P=0.37$)



With community training: also a non-significant inverse correlation ($r=-0.20$, $P=0.33$)

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