

REPORT ON THE THIRD INTERCOUNTRY WORKSHOP ON THE IMCI COMMUNITY COMPONENT

TABRIZ, ISLAMIC REPUBLIC OF IRAN

24-27 JULY 2005



World Health Organization
Regional Office for the Eastern Mediterranean
Child and Adolescent Health and Development Unit

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ON THE IMCI COMMUNITY
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1. Introduction

The Regional Office for the Eastern Mediterranean (EMRO) of the World Health Organization (WHO) held the Third Intercountry Workshop on the IMCI (Integrated Management of Child Health¹) Community Component in Tabriz, Islamic Republic of Iran, from 24 to 27 July 2005. The objectives of the workshop were to review the status of implementation of the IMCI community component in the Eastern Mediterranean Region, and to review and update the plan of action for the IMCI community component in 10 countries of the Region.

A total of 44 participants attended the workshop, including 31 national and sub-national representatives of 14 countries involved in the IMCI strategy in the Region, one representative from the Aga Khan Development Network (Syrian Arab Republic), 5 staff members from UNICEF country offices, and 7 staff members from WHO headquarters, Regional Office and country offices. The agenda and programme of the workshop are shown in Annexes 1 and 2, respectively; the list of participants is given in Annex 3.

This workshop was a follow-up to two previous workshops held in Cairo in 2002 and 2003, respectively, for a total of 11 participating countries, in which plans of action were developed for the IMCI community component by each country team. These workshops were organized as part of the Regional Office efforts to promote key child care family practices at community level in countries already implementing the IMCI strategy in health facilities. Recognizing the need to develop sound plans as a first and critical step, the focus of the workshops was on the planning process. A framework for the community component of the integrated child care strategy was developed by the Regional Office in consultation with countries and was reviewed in an intercountry meeting in Lattakia, Syrian Arab Republic, in 2001.² In addition, guidelines for planning for the IMCI

¹ Globally known as the Integrated Management of Childhood Illness, the IMCI strategy has evolved in the Region to include also child health and development and, while keeping the same acronym, has developed into the Integrated Management of Child Health.

² *Framework for the community component of the integrated child care strategy*. Cairo, World Health Organization Regional Office for the Eastern Mediterranean, 2002 (WHO-EM/CAH/003/E). Available at <http://www.emro.who.int/cah/CommunityComponent-Planning.htm#Section2> in English, French and Arabic

community component were developed by the Regional Office as a tool to guide and facilitate the planning process.³

The important role played by IMCI as a strategy to reduce under-five mortality and thus contribute to achieving Goal 4 of the Millennium Development Goals (MDGs) was highlighted by all the speakers in the opening session, including Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, Dr Masoud Pezeshkian, Minister of Health and Medical Education of the Islamic Republic of Iran, Dr Ahmad Reza Joudat, Chancellor of Tabriz University of Medical Sciences, and Dr Mohamed Ali Sobhanalli, Governor General of East Azerbaijan Province. Dr Gezairy emphasized that, together with interventions to incorporate the main elements of IMCI in the teaching at medical and paramedical schools, the IMCI community component was key to sustainability: families and communities are key actors and most decisions on child care are made and carried out at that level. A strong link needs to be established between the health system and the community.

2. Progress of child health activities in the Region

2.1 Overall progress

Child health is being re-stated as a global priority. Goal 4 of the MDGs specifically relates to reduction of under-five mortality, while some of the other Goals also relate directly or indirectly to child health. A special report of the United Nations Millennium Project Task Force on Child Health and Maternal Health, *Who's got the power? Transforming health systems for women and children* (2005), recommends rapid and equitable scale-up of the IMCI strategy to achieve the Goal 4. Recent World Health Assembly resolutions have addressed child health issues (e.g. child health strategy, infant and young child nutrition, strategic directions for achieving the MDGs, working towards universal coverage of maternal, newborn and child health interventions). Maternal and child health was the subject of *The World Health Report 2005* and World Health Day 2005. Child health has also been recognized as a priority by the Regional Office. A technical discussion paper of the past Regional Committee for the Eastern Mediterranean (RC51) in 2004 was entitled to "Moving towards the Millennium Development Goals: Investing in maternal and child

³ *Planning steps for the IMCI community component at national level - A working document*. Cairo, World Health Organization Regional Office for the Eastern Mediterranean, Revised version, August 2003. Available at <http://www.emro.who.int/cah/CommunityComponent-Planning.htm#guide>

health”, and resulted in a resolution (EM/RC51/R.4) which urged Member States to develop national child health policy documents and strategies, scale up implementation of the effective interventions of IMCI and incorporate public child health approaches related to maternal and child health into the formal teaching curricula of medical and paramedical schools.

A systematic approach to IMCI planning and implementation is followed in the Region at both national and district levels, with efforts also made to improve drug availability, organize work at the health facility and strengthen supervision, and with some countries testing approaches at community level to improve family child care practices. The figures available up to mid-2005 show remarkable progress in expanding IMCI implementation over recent years, with about 56 000 health providers trained in IMCI case management and over 50% of all targeted primary health care facilities in 11 countries implementing IMCI provided with staff trained in IMCI. A total of 19 medical schools and 2 nursing schools have introduced the IMCI approach into their teaching in paediatrics or community medicine and an IMCI pre-service training evaluation tool is under development by the Regional Office to review the experience and assess its impact.

To support the development of national child health policies, a Child Health Policy Initiative was launched in October 2004, in which 5 countries of the Region are currently participating. A document was developed by the Regional Office to guide the process⁴, resulting in the drafting of child health situation analysis country reports (section 10.3). As part of advocacy initiatives in the period 2004–2005, national awareness-raising days focusing on child health were held in Sudan, Syrian Arab Republic and Tunisia. As well, the Regional Director formally visited IMCI-implementing areas and medical schools teaching IMCI in Egypt together with high government officials and academic staff. A website on child health and development was prepared by the Regional Office and launched on 7 April 2005 on occasion of the World Health Day, which was dedicated to maternal and child health. The Regional Office is also involved in developmental work, including the preparation of child feeding counselling training materials in Arabic, a pre-service training evaluation tool, research to develop guidelines on the management of burns and poisoning in children at primary health care level, and an IMCI district planning guide (section 10.3).

⁴ *Development of National Child Health Policy. Phase I: The Situation Analysis*. Cairo, World Health Organization Regional Office for the Eastern Mediterranean, 2004. (WHO-EM/CAH/014/E). Available at <http://www.emro.who.int/cah/childhealthpolicy-situationanalysis.htm> in English, French and Arabic

Despite the progress described above, trends in under-five mortality for the Region suggest that Goal 4 is unlikely to be met on a regional scale unless statements of support of decision-makers are translated into action in countries, and intensified efforts and unprecedented political commitment and policy support are provided to child health, scaling up IMCI implementation at health facility and community levels to provide equitable access to quality child health care, address the chronic and critical issue of human resources and strengthen planning and management capacity.

2.2 Progress in implementing the IMCI community component

Progress in the implementation of the IMCI community component was reviewed by presenting information that had been collected through a questionnaire sent to the participating country teams before the workshop and discussing issues with the participants in small groups.

- *Establishment of a coordination structure and political commitment.* Most countries (10 out of 14) had set up an IMCI community component working group to coordinate activities at national level within the IMCI strategy context. However, these working groups were given less attention than training. Only in a few cases did the community component working groups seem to be active and functional, as progress in implementation was very slow. In some cases, the large number of members of the group had been a constraint to meeting more frequently: the composition of the group had been revised or would benefit from a revision (downsizing). An issue raised during the group work concerned the lack of commitment at national and sub-national level.
- *Selection of family practices to be promoted.* Most countries went through the recommended process of prioritizing practices in order to select a few to promote at the beginning. All countries selected a high number of child care practices, ranging from 6 to 12, out of the WHO-recommended list of 12, except Djibouti, which focused on 3 practices. The importance was recognized to focus first on a few practices and build on those before expanding interventions to others.
- *Development of plans.* Only 6 out of the 14 countries reported they had prepared annual plans for the community component, fewer included indicators—mostly process-related—and only 3 set targets for them, thus making it very difficult to carry out interventions and monitor progress. The focus was mostly on

training of community volunteers or IEC materials, with the plans lacking a comprehensive approach. It was acknowledged that the country plans developed originally at the intercountry workshops on the community component in 2002 and 2003 tended to be overambitious. Oman had followed a unique “bottom-up” plan development process. While most countries (9 out of 14) selected geographical areas to start implementation, the number of areas to be involved was small (less than 100 for the whole Region). The criteria used for selection commonly included: availability of committed staff in those areas; poor child health indicators; high under-five population; access to health services (easy access chosen in some countries to facilitate follow-up during the pilot phase; low access chosen by other countries to benefit difficult-to-reach, remote areas most in need for health interventions); ongoing implementation of the IMCI strategy at health facilities in the same areas; and presence of nongovernmental organizations or existence of community-based interventions.

- *Interventions, links with the health system and community involvement.* The lack of strategies, with few exceptions, made the interventions often look like isolated activities, mostly focusing on training of community volunteers and development of some IEC materials (including television spots in 2 countries), usually without proper pre-testing or monitoring of information on community exposure to them. The role of the health facility and health system in linking with the community intervention was usually unclear. The notion of community involvement was present in many cases, while the modalities of involvement usually concerned only some aspects of the interventions, and information on community satisfaction with the interventions was rarely collected. Thus, community interventions were not adapted to take into consideration the communities themselves.
- *Documentation of interventions and outcomes.* It was in general recognized that documentation of interventions had been poor or absent in most cases and this had prevented learning effectively from experiences and sharing evidence in support of the various approaches followed in countries.
- *Financial resources, advocacy and partners.* WHO and UNICEF were the most common source of funding for the IMCI community component in most countries, with United States Agency for International Development (USAID), Save the Children and a few other partners indicated in few individual countries. Partners were involved in different aspects of the projects in most countries. There was common agreement on the need to advocate more effectively to orient partners (including civil society) in order to

- build stronger partnerships—also outside the health sector—and raise more funds.
- *EMRO guidelines on the IMCI community component.* Most countries found the framework and planning guide developed by the Regional Office very helpful, clearly written and presenting a standard and practical approach to planning. Only few country reports mentioned having not seen these documents.
- *Lessons learnt.* Four common lessons were learnt from countries in this phase: 1) there is partner interest in community interventions; 2) the lack of experience in this area had been responsible for slow progress; 3) the lack of human and financial resources had been another important constraint; and 4) the lack of regular information flow between countries and the Regional Office had been another factor limiting the type of support that WHO could provide to countries to address their needs.

3. Key family practices: review of the evidence and prioritization

To help countries prioritize investments to promote family child care practices, a technical document was prepared by the London School of Hygiene and Tropical Medicine for WHO in 2004, entitled *Family and community practices that promote child survival, growth and development: A review of the evidence*. The document summarizes the evidence available on the feasibility and impact on child health of interventions promoting the 12 key family practices (see Annex 4), identifies gaps in knowledge and makes recommendations for further research. For each family practice, the document describes: a) the prevalence of the key practice; b) its benefits in terms of *efficacy*; c) the impact of interventions implemented under usual conditions to increase the practice level in the community (*effectiveness*); d) the feasibility and sustainability of large-scale interventions; and e) conclusions and questions yet to be addressed. The document points out that the potential impact of interventions depends on the current levels of the key practice, the strength of the relationship between the practice level and child health outcomes (mortality, growth and development), and the degree of success that can be achieved in increasing the practice level in the target population. The document is intended to assist public health managers in deciding which practices to select for promotion and in the planning process. It suggests a number of factors to be considered, including: the expected level of impact of the intervention to be undertaken; the complexity of the behaviour change involved, its frequency (how often it needs to be performed by the target audience) and sustainability;

the required inputs at household and health facility levels; the current level of development of the interventions; and the estimated length of time required for implementation. It emphasizes that the key family practices involve several different behaviours: changing behaviours is complex, takes time, entails addressing cultural barriers and enabling factors, and must be promoted together with the provision of related services. The review concludes that while there is evidence about the success obtained with some interventions (e.g. increasing immunization coverage, use of oral rehydration salts and malaria bed-nets), more evidence is needed for large-scale interventions to promote other practices (e.g. family recognition of when to seek care, compliance with provider's advice).

The body of evidence presented in the review document helps in selection of which key family practices to promote and in which interventions to invest resources. The Regional Office recommends that only few practices should be selected at the beginning, to concentrate resources and efforts and increase chances of success. A thorough situation analysis should guide the selection and planning process. Other key factors, such as partner interest, should also be considered.

4. Communication design process

Communication is at the heart of community interventions which aim to improve key family practices. It is an element of a public health programme and is effective if it is based on a comprehensive plan and audience research, uses a few messages and various channels of communication in an integrated way, and encourages dialogue between users and providers. Over the years, public health communication has evolved from a "piecemeal approach" to a process, from isolated activities to a comprehensive strategy, moving beyond the so called "poster syndrome". The purpose of this session was to present and review with the participants a 6-step communication design process for a communication strategy (Figure 1), where each step builds on the success of the previous one, to be integrated in the overall planning process for the IMCI community component. Group and plenary discussions followed introductions to the various steps.

Communication design process

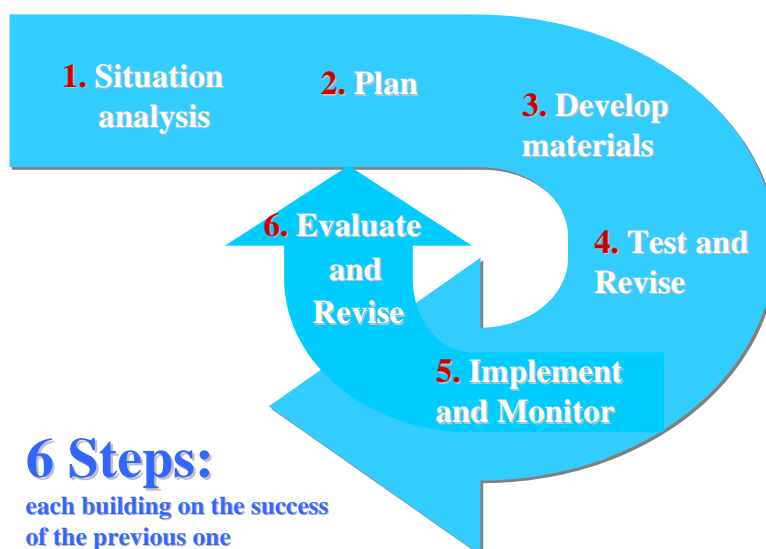


Figure 1. The 6-step communication design process

Much attention in the session was paid to step 1, the situation analysis, because it is a critical step based on which the communication plan should be designed. At the same time, it is a step often neglected and replaced by beliefs and anecdotes rather than based on evidence. The situation analysis aims to investigate the problem (epidemiological analysis), the audience, communication networks (characteristics of media and other channels, including interpersonal communication) and resources (e.g. resources for training, production and distribution of IEC materials, mobilization of health providers and civic groups, monitoring and evaluation, research), and the “Ps” of marketing (product or practice, price, place and promotion). This information provides the key elements to define and select the target audience, the behaviours to be promoted and the interventions to promote them in the target audience: it is therefore *essential* to planning. The failure of many public health education initiatives is often due, among other things, to overlooking this step. The audience concerns not only those who are expected to perform the recommended practice (“primary audience”) but also those who can influence the former (“secondary audience”), thus creating an amplifying effect and a strong supporting environment. Common demographic, socio-cultural, geographical and behaviour characteristics of the audience need to be described specifically to identify and select relevant sub-groups for the intervention (“audience segmentation”). Behaviour analysis aims to understand not only what people do (current practices) but also the reasons for what they do,

including barriers and enabling factors for the desired practices, what motivates and influences them, potential advantages of the desirable practice versus the current ones and issues faced in adopting the practice. This understanding is key to addressing main determinants of behaviour and designing effective interventions accordingly. In fact, simply telling people “what to do” seems to be less effective and less acceptable to the audience itself.

Next, a plan for the communication intervention should be developed, relying on the information of the situation analysis. As confirmed by the information provided by countries and summarized in section 2.2, activities in countries are often undertaken without a plan which sets a clear direction. Attention was therefore paid in the session to this step of the process, emphasizing the importance of stating clear objectives, selecting indicators and related targets to be achieved, detailing all key elements of the communication strategy, and specifying the other traditional components of plan (assigning responsibilities, defining a timetable and resources). A whole range of indicators should be included in the planning document, related to process (input and output), intermediate and final outcomes. This would enable programme managers to monitor: whether the target audience is being exposed to the materials; whether the target audience has tried and then adopted the practice promoted; and eventually, the impact on health, which should remain the primary goal of the intervention (Figure 2). The plan should describe the necessary strategies for materials development, testing and finalization, materials distribution, training, phasing, use of multiple media channels (“media mix”) and monitoring and evaluation.

The third step focused on the characteristics to consider when developing messages and materials. Other steps of the process were reviewed more concisely, while highlighting some key points, such as the essential need to keep track of implementation (including documenting the intervention) and to monitor the indicators set out in the plan. Finally, it was stressed that any behavioural change initially promoted must be sustained over time: programme managers should take this into consideration into their plans.

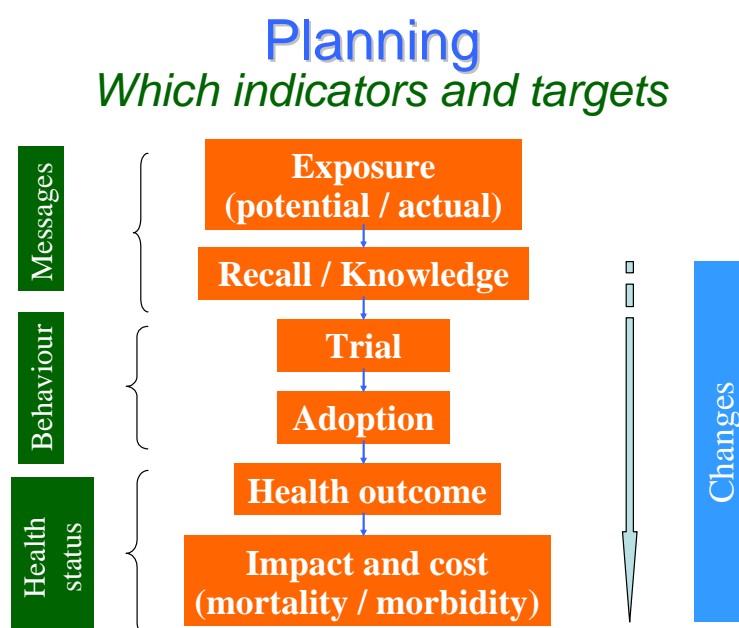


Figure 2. Planning: identifying indicators

5. Country experiences

5.1 Sudan: community volunteers and mass media

Sudan was the first country in the Region to introduce the IMCI strategy, in 1996. Initial attempts to develop a community component in 1999, when implementation started at district level, lacked a comprehensive vision. Later, a multisectoral national task force on the IMCI community component carried out a mapping of partners at sub-national level. Following a WHO regional workshop in which the EMRO framework and planning guide were used to plan for the community component, the task force planned for the conduct of knowledge, attitudes and practice (KAP) surveys focusing on nine of the WHO-recommended family child care practices, to collect quantitative data on their level in selected communities. The information was also to serve as the basis for the selection of 3–4 practices to promote in local communities out of the original 9 practices.

The communities to be targeted by the intervention were selected based on a number of criteria reviewed by the country team in the regional workshop. These criteria included the existing implementation of the IMCI strategy in the same area; a high under-five population; poor performance of child health indicators; and

availability of interested and committed partners and community-based interventions on which to build, such as basic development needs and Child-Friendly Community Initiative projects, and committed staff. Of the interventions initially taken into consideration, focus in implementation was placed on health education, through the use of volunteers as community health promoters, and mass media. Training materials were developed for the volunteers, who were to carry out home visits and conduct health education on the key family child care practices. Work started to develop radio and television spots for the mass media approach. An important result of the various activities undertaken was the development of partnerships for child health. To monitor implementation, indicators were selected for both the process (e.g. number of communities covered by the intervention, volunteers who had received supervisory visits) and outcomes (e.g. caretakers who sought care from a health facility after receiving the volunteer's visit). Supervision by state staff and linkages with the health system were found to be rather weak. A post-intervention evaluation in two communities yielded encouraging results, especially with regard to caretaker knowledge about the selected key family practices. It also highlighted the need to invest more in capacity-building, use of monitoring tools and conducting supervisory visits, coordination with partners and coverage by mass media.

The main lessons learnt were that many partners were available and interested, and that communities which were organized through existing community-based initiatives could facilitate implementation. Achievements were also considered: the establishment of a functional multisectoral working group at national level and in 6 states, the collection of information from available sources and additional information through KAP surveys, the definition of criteria for selection of target communities, and the development of a variety of promotional materials, including posters, calendars, pamphlets, and television and radio spots. The promotional material, however, was not developed within the context of a communication strategy and timetable for implementation, to be used in a concerted way to reinforce messages through multiple channels. This issue, coupled with the lack of qualitative information on the target audience and on the determinants of their behaviour (no formative research was conducted), and inadequate testing of materials, represented a substantial weakness in the overall approach. The need for better coordination of activities between partners and for defining outcome indicators (setting related targets) was highlighted. The training package for volunteers was inadequately tested and later found too complex, with a revision planned in 2005. The high turnover of master trainers and trained volunteers was described as a constraint,

especially for a decentralized approach such as this one, aiming to reach many communities in the countries. As well, monitoring and supervision—including training of supportive staff—were reported as weak, thus making it difficult to learn from the experience.

5.2 Oman: social marketing

Oman formally endorsed the IMCI strategy in 2001 as a national strategy and, like many other countries, initially focused action on the health system. An IMCI working group was set up in 2002 and 5 key family child care practices were selected as priorities at national level for promotion in the country. Following participation in the intercountry workshop on the community component in 2003 and the recommendation to concentrate initially on a few practices and later build on that, a plan for the IMCI community component was reviewed. The plan placed particular emphasis on social marketing as an approach. A framework was developed and implementation followed a number of steps. First, a situation analysis was carried out. Qualitative methods, e.g. focus group interviews, were used to collect information on the target audience—mothers of under-five children—and behaviour. Next, a plan was developed for a mass media campaign. A variety of promotional materials on the selected child care practices were developed and tested among the target audience. Materials included leaflets, radio spots, newspaper articles, a newspaper quiz (“Learn and win”), a brochure quiz, and audio and video materials (interviews, drama). The campaign was launched in February 2004 during the Muscat Health Festival.

Telephone interviews were conducted to assess mother’s recall of the brochure and its content. A high rate of recall was reported, together with a positive attitude towards the child care practices promoted. Programme managers reported a positive perception about the social marketing approach used to promote child care practices. The “Learn and win” quiz was found to be very popular in the Omani context. Radio spots likely contributed to improving mothers’ recall of the messages contained in the written promotional materials. A major limitation was the very short time allocated to the campaign (several weeks)—mostly due to the limited scope of the plan and hence limited resources allocated. Any potential achievement made with such a short campaign was unlikely to have a major impact on behavioural changes and health outcomes.

The review of the Omani experience by the workshop participants, while acknowledging the inclusion of process indicators

in the plan, highlighted the lack of outcome indicators and related targets to measure the impact of the intervention. Government commitment, participation of the community during the focus group discussions and the use of multiple media channels were perceived as positive elements of the Omani experience. It was also felt that partner involvement in the planning process had been weak. As well, telephone interviews were the only assessment made and focused more on recall of media events and knowledge of the practices promoted, with basically no information collected on the performance of the practices by the target audience. The Omani team felt that more advocacy was needed to raise the resources required to sustain similar approaches over time in the future and increase their likelihood of contributing to behavioural change.

6. Plans of action

Participants, grouped in country teams, were asked to develop a 12-month plan of action to promote one key family child care practice as a model, applying the concepts and following the recommended process reviewed in the workshop. The plans, due to be finalized by the end of the first week of September 2005 and shared with the Regional Office, will help follow up implementation in countries.

7. WHO role in supporting countries

A session was held for the participants to identify the areas in which they felt WHO could best support countries in moving forward the community component, based on the presentations and discussions in the workshop. The following areas were identified.

- Advocacy and partnership
 - Advocate for child health at policy level in countries.
 - Enhance public managers' advocacy skills, e.g. through training courses.
 - Further intersectoral collaboration.
 - Create or foster "child alliances".
 - Promote and facilitate partnerships for country support.

- Planning
 - Enhance opportunities for the IMCI community component and community-based initiatives (e.g., BDN) to build on each other.
 - Standardize the planning process for the IMCI community component including the communication strategy with a view to evaluating it.
- Communication strategy
 - Provide support in the area of behavioural change.
 - Develop guidelines on the preparation of “messages” for communication interventions.
- Country support
 - Follow up implementation of country plans of action in countries as feasible.
- Information sharing
 - Share lessons learnt from country experiences related to the IMCI community component, as done in the workshop. Although experiences may be very country specific and use models far from ideal, the lessons learnt from them are of particular value to other countries. This would also require that countries share more information with the Regional Office about their experiences, and share it more frequently.
- Evaluation
 - Support countries in evaluating IMCI community component country experiences (see “Information sharing” above).
 - Provide support to evaluation (e.g. surveys) and research activities, including the development of new tools.

Countries are encouraged to ensure that adequate financial resources are included in WHO biennial country programme budgets to support the roles and tasks described above.

8. Country exhibition

A “marketplace” session was organized in which countries displayed information and IEC materials on child health developed locally, and “marketed” them to the other country teams through a brief introduction. A number of audiovisual materials were also shown. In general, the session stimulated much interest among the

participants and showed the variety and wealth of initiatives undertaken by each country, highlighting the need—already expressed on many other occasions during the workshop—to share them more regularly with the Regional Office for dissemination to other countries in the Region.

9. Collecting and reporting information on IMCI indicators

Participants brainstormed in groups about indicators and tools available to measure them. Different countries are currently using different indicators: the use of a few standard, key indicators across countries was recognized as helpful, also to enable to compare and share experiences. There was agreement on the advantage of collecting information on both process and outcome indicators, to monitor progress in implementation and take timely measures based on it. While some indicators need to be measured at all levels, the measurement of other indicators could be limited only to lower levels than national, for action at that specific level, and the information would need not to be reported to higher levels. A key criterion must be the extent to which data will eventually be used for action. Five additional, important points were made on indicators.

- Denominators: indicators should include denominators, i.e. be expressed as rates, percentages or proportions (numerator included in the denominator) or ratios (numerator not necessarily included in the denominator, e.g. comparing measures of different nature). This would enable to measure progress over time, between areas in a country and across countries. Reporting total numbers should in principle be avoided.
- Validation: data collected should always be critically reviewed and validated as much as possible, before being used or reported.
- Qualitative information: should also be collected, to have in-depth information (“why”, “how”) and to aid interpretation of quantitative data (“how many”, “what”), possibly through easy-to-use and participatory approaches.
- Integration: data on child health should preferably be collected and reported through integrated systems.
- Other sources: data collected by partners should also be considered and used, after establishing working mechanisms to share them.

Participants recognized the difficulty in collecting data systematically, especially at community level. There exist examples of

countries which are doing so, e.g. Pakistan (Lady Health Worker programme), Yemen (reports from volunteers) and Islamic Republic of Iran. Other examples include reports from home visits in a few countries. Special campaigns, such as national or sub-national immunization days, are opportunities to collect additional information at community level. Follow-up visits after IMCI training currently represents a useful source of health facility-based information; with proper adaptation, the methodology could be used to collect information on key health provider performance indicators periodically. It was proposed to establish an e-discussion group to develop a list of key indicators for the IMCI community component. It was also agreed that countries would report information on IMCI coverage and those indicators to the Regional Office regularly (at least every six months).

10. Technical updates

10.1 Technical updates on the IMCI guidelines

The generic IMCI guidelines, developed about 7 years ago⁵, were recently updated to reflect new evidence from research carried out in recent years. Six areas were updated, as described below.

- ***Treatment of severe and non-severe pneumonia (in countries with low prevalence of HIV) and of children with wheeze***
 - *Treatment of non-severe pneumonia in children 2 months to 5 years:* The new recommendations concern duration of treatment (shortening the recommended antibiotic treatment course with cotrimoxazole or amoxicillin from 5 to 3 days), choice of antibiotic where resistance to cotrimoxazole is high (preference for oral amoxicillin) and frequency of administration for oral amoxicillin (25 mg/kg/dose two times daily in place of 15 mg/kg/dose three times daily, as now recommended also by the American Academy of Pediatrics).
 - *Treatment of severe pneumonia in children 2 months to 5 years:* Changes concern the choice of treatment, with injectable ampicillin plus gentamicin preferred over injectable chloramphenicol in very severe pneumonia cases.
 - *Children with wheeze and fast breathing or lower chest indrawing:* A trial of rapid-acting bronchodilator (up to three cycles) is recommended before classifying them as pneumonia and prescribing antibiotics.

⁵ The full technical document is available at:
http://www.who.int/child-adolescent-health/publications/IMCI/ISBN_92_4_159348_2.htm

- **Management of diarrhoea**
 - *Use of low-osmolarity oral rehydration salts (ORS):* Low-osmolarity ORS is now recommended for the management of dehydration: it reduces stool output by 20%, vomiting by 30% and the need for unscheduled intravenous fluids by 33%.
 - *Zinc supplementation:* Along with increased fluids and continued feeding, zinc supplementation should be given to all children with diarrhoea for 10–14 days (10 mg/day in infants less than 6 months and 20 mg/day in older children). It reduces the duration and severity of the diarrhoea episode and lowers the incidence of diarrhoea in the following 2–3 months.
 - *Treatment of bloody diarrhoea:* Ciprofloxacin is now recommended as first-line antibiotic in place of nalidixic acid (15 mg/kg 2 times a day for 3 days).
- **Treatment of fever/malaria**
 - *Artemisinin-based combination therapy (ACT):* While IMCI adaptations usually follow the national antimalarial drug policies, which vary from country to country, ACT improves treatment efficacy and is a valid therapeutic option now available. When ACT is introduced, diagnosis should rely on laboratory (microscopy) or rapid diagnostic tests.
- **Management of ear infections**
 - *Use of antibiotics in chronic ear infections:* Based on findings from a Cochrane review, combined treatment of aural toilet and antibiotics is now recommended, as it has proved to be superior to aural toilet alone. Topical antibiotics are more effective than systemic antibiotics. Daily instillation of topical antiseptics or topical antibiotics after meticulous dry ear wicking for at least 2 weeks is the most cost-effective treatment for the short-term resolution of otorrhoea.
 - *Use of antibiotics in acute ear infections:* Based on a recent consultative meeting, oral amoxicillin is considered a better choice for the management of acute ear infections in countries where antimicrobial resistance to cotrimoxazole is high.
- **Infant and young child feeding**
 - *Exclusive breastfeeding:* Exclusive breastfeeding is recommended for 6 months (180 days) on a population basis, as it has shown to have a protective effect against gastrointestinal infections in children in developing and developed countries and represents an advantage to the

mother in prolonging the duration of lactational amenorrhoea, with no adverse effects on infant growth.

- *Complementary feeding in breastfed children:* Assuming a diet with energy density of 0.8 kcal per gram or above and low breast-milk intake, recommended meal frequencies for breastfed children on a population basis are: 2–3 meals for infants aged 6–8 months, and 3–4 meals for infants aged 9–23 months with additional nutritious snacks offered 1–2 times a day as desired. Responsive feeding is critical for enhancing nutrient intakes, in addition to promoting complementary food diversity and food fortification or supplements. Therefore, the current IMCI guidelines for complementary feeding remain valid in developing countries.
- *HIV and infant feeding:* In areas where HIV is a public health problem, all women should be encouraged to receive HIV testing and counselling. If a woman is HIV-positive and replacement feeding is acceptable, feasible, affordable, sustainable and safe for her and her infant, avoidance of all breastfeeding is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life. This is because the risk of HIV transmission can be estimated as follows:

During pregnancy	5%–10%
During labour and delivery	10%–15%
During breastfeeding	15%–20%
Overall without breastfeeding	15%–25%
Overall with breastfeeding until 6 months	25%–35%
Overall with breastfeeding until 18–24 months	30%–45%

○ ***Management of helminth infestations in children under 24 months***

- *Age at which to start treatment:* In areas with a high burden of helminthiasis, i.e. hookworm (*Ancylostoma* and *Necator*) or whipworm (*Trichuris*), regular deworming with a single dose of 500 mg of mebendazole (or albendazole) every six months is recommended for all children with anaemia age 12 months or older as an effective public health measure, rather than 24 months or older as previously recommended. As there is a paucity of safety data regarding the use of these drugs in infants under 12 months, such cases should be managed on a case-by-case basis.

- **Children with HIV infection**
 - *Clinical care:* Guidelines for the assessment, classification and treatment of these children have been developed in the African Region and validated through studies. Together with an adaptation guide, they will become available soon.

10.2 Recent developments in the area of child health

Of the 10.6 million children under five years old who die every year worldwide, 4 million, or about 38%, die within 28 days of birth, the neonatal period.⁶ Uneven progress in newborn mortality reduction has been observed among different geographical regions in the past few decades, as opposed to the steady progress achieved in reducing mortality in older children. Three quarters of the neonatal deaths occur in the first week of life, i.e. at a time when coverage of care is lowest. Globally, the main direct causes of these deaths are severe infections (36%), pre-term births (28%) and asphyxia (23%), with low birth weight being an important indirect cause of deaths: thus, many of these deaths are preventable. The distribution of deaths varies according to the level of neonatal mortality, e.g. severe infections contribute proportionally more to all newborn deaths in settings with higher neonatal mortality rates than settings with lower neonatal mortality levels, while the opposite pattern is observed for pre-term causes. Poverty remains an underlying cause of many neonatal deaths. The vast majority (90%) of deaths are in just 42 countries, among which Pakistan in our Region is one of the six major contributors in the world.

Interventions exist with proven efficacy to reduce neonatal deaths. Their implementation, together with other child survival interventions, is critical to achieve the Millennium Development Goal 4 on under-five mortality reduction. It has been estimated that universal coverage (99%) with those interventions could avert 41%–72% of neonatal deaths globally. Unfortunately, global coverage of child survival interventions, including those for neonates, is low. A “continuum of care” is required, both in terms of time (from pre-pregnancy through pregnancy, childbirth, the crucial early days and years in life) and place (family-community, outreach and health facility-based services). Within this context, three existing partnerships on newborn health, safe motherhood and child survival, respectively, have merged into one global partnership on maternal, newborn and child

⁶ The Lancet series on child survival and on neonatal survival are available at:
http://www.who.int/child-adolescent-health/NEWS/news_27.htm
http://www.who.int/child-adolescent-health/publications/NEONATAL/Lancet_NSS.htm

health, to advocate for increased support and funding, scale up child survival interventions in the 42 countries with greatest needs and track progress. Constraints to political commitment, financing of the health sector and human resources will have to be addressed effectively and overcome in order to reach the MDGs. IMCI is a cost-effective strategy, has been accompanied by increased health facility utilization, remains a key strategy on child health and has in the Region included newborn care elements in its clinical guidelines. These guidelines on newborn health were recently revised globally and are being validated, with results expected in 2006.

10.3 Update on developmental work carried out by the Regional Office

Development of national child health policies

An area increasingly recognized as a priority is the development of national child health policies. Such policies support implementation of child health strategies by providing long-term directions and commitments and addressing issues adversely affecting investments in child health, such as competing health priorities, inadequate government investment and underutilized partnerships. In October 2003, the Regional Office launched the Child Health Policy Initiative (CHPI)⁷ which was initially joined by 5 countries, namely Egypt, Morocco, Sudan, Syrian Arab Republic and Tunisia. The initiative aims to assist countries in developing written national child health policy documents, recognized as a requirement for long-term sustainability of interventions to improve and sustain child health and development, identifying priorities and harmonizing partners' actions and contributions to ensure equitable access to health care. The Initiative proposes 3 main phases for the policy development process, namely:

- Phase I: Situation analysis
- Phase II: Development of the policy document
- Phase III: Official adoption of the policy document

As a sound policy needs to be informed by good data, the Regional Office developed in 2004 a document to guide the first phase of the process, *Development of national child health policy. Phase 1: The situation analysis*. The document has been made available in English, Arabic and French, to make it accessible to all countries in the

⁷ More information is available at <http://www.emro.who.int/cah/childhealthpolicy.htm>

Region⁸. The situation analysis prepared by the countries which have joined the initiative will be presented in a workshop in November 2005. A few other countries which have expressed interest in the Initiative will also be participating in that workshop.

Child feeding counselling training materials

Given the importance that nutrition counselling plays in child health, the Regional Office has developed a training package on child feeding counselling, which focuses on communication skills and how to use them for counselling mothers on breastfeeding and complementary feeding. The training materials: are based on the WHO training materials on breastfeeding counselling and updated scientific references on breastfeeding and complementary feeding; reflect regional experience in conducting these courses and cultural peculiarities; and include a section on counselling on complementary feeding and in special conditions. The materials were originally developed in Arabic—the language spoken in most countries in the Region—field-tested and revised, and are expected to become available by the end of 2005. An English version is under preparation and should become available in early 2006.

District planning guide

Regional experience in child health has repeatedly shown the need to strengthen capacity for planning at all levels of the health system. As an IMCI planning guide is available for the national level, the Regional Office is developing a guide that would assist the IMCI planning process at district level, i.e. the implementation level. This has become increasingly important also in view of health system decentralization in a number of countries. The guide, which is under development, identifies 4 phases in district planning: 1) a preparatory phase, 2) the district planning workshop, with the development of a plan of action; 3) monitoring of the implementation of the plan of action; and 4) review of implementation and re-planning.

Research on poisoning and burns

Injuries are a growing and largely preventable public health problem in children. They are responsible for an estimated 3% of all under-five deaths globally and represent one of the leading causes of death in the age group of 1–4 years in some countries in the Region.

⁸ The document in the 3 language versions is available at <http://www.emro.who.int/cah/childhealthpolicy-situationanalysis.htm>

As many injuries often go unreported, and burns statistics tend to relate only to fire burns—while scalds are the most frequent causes of burns in children—the real burden of injuries in children is therefore largely underestimated. For every death, there are many consultations, hospital admissions and permanent disabilities. The “cost” to individuals, families and society is high. The Regional Office has therefore decided to address some common causes of injuries in children, namely poisoning and burns, which together with falls and drowning represent major contributors to the burden of injuries in children. Finally, the management of children with poisoning and burns at primary health care level is often carried out without clear guidelines, resulting in over- or under-treatment with important implications for child outcome and use of resources.

The initiative consists of 2 main phases. The first is *curative*, focusing on the development of standard clinical guidelines for the PHC level in an IMCI-format. The second phase is *preventive*, investigating community interventions which can prevent unintentional poisoning and burns in children under-five.

As part of the first phase, a clinical decision rule for the early identification of cases needing referral has been developed for children with exposure to hydrocarbons (e.g. kerosene, gasoline). The rule, based on a prospective study conducted at the Ain Shams University Hospitals Poison Control Centre in Cairo, Egypt, and coordinated and supported by the Regional Office, needs to be validated in other settings. Recruitment of cases exposed to organophosphates and carbamates (e.g. insecticides) is about to be completed at the same Centre and data analysis for the development of the clinical decision rule is expected to start in the last quarter of 2005.

In the area of burns management, a clinical protocol has been developed and reviewed by a number of burn centres within and outside the Region, with input provided also through an ad hoc e-discussion group. A technical review paper on management of burns in children was also commissioned to provide the supporting evidence and identify gaps in knowledge; it should be ready in the last quarter of 2005. The clinical protocol will need to be validated in clinical settings. A library of photographs on burn cases has been developed to develop training materials.

10.4 Child health website

The Regional Office has developed a website on child health with relevant information from the Region. The website was evaluated through an initial questionnaire sent to a list of individuals involved in child care in countries and was well received. It is structured into 9 main sections: IMCI; pre-service education; health system support; community component; Millennium Development Goals; child health policy; evaluation and research; documents and reports on regional activities; and advocacy and partnership. The home page features news on recent regional and country events, and scientific updates and e-mail alerts are automatically sent to registered users.

11. Conclusions

- Participants acknowledged the efforts being carried out to make child health a priority (World Health Assembly and Regional Committee resolutions, support to IMCI implementation, etc.).
- Participants appreciated the commitment made by decision-makers at all levels within organizations and countries to strengthen support to child health.
- Participants acknowledged the significant progress that has been made in the Region in the implementation of the IMCI strategy, including planning for the improvement of family and community practices.
- Participants appreciated the efforts of the Regional Office in developing a standard framework for planning the IMCI community component.
- It was observed that the implementation of the community component of IMCI is still lagging. Factors such as lack of capacity and resources in this area, lack of clear understanding and unavailability of standardized tools for guiding implementation were described as possible reasons.
- Reports from countries clearly indicated that some countries were going through a process of training material development for community health workers/promoters.
- Experience with the IMCI community component in the Region is currently not systematically documented by countries.

- The success in the Region in implementing the first two components of IMCI has been attributed to the systematic approach followed, from planning to implementation and investment of resources. This systematic approach has not been followed for the IMCI community component in countries. This has resulted in lack of sound planning with clear objectives, targets, indicators, priorities and activities, at national and implementation levels.
- Most national plans for the IMCI community component currently include a list of isolated IEC activities, which were not developed as a communication strategy and are not part of a comprehensive plan.
- The workshop provided opportunities for sharing experiences, identifying obstacles to implementation and potential solutions. At the same time, it provided participants with an opportunity to go through a systematic planning process that resulted in drafting country plans.
- The marketplace was regarded by participants as very useful. It demonstrated the wealth of materials developed by countries, and provided countries with opportunities to learn from each other.
- Participants discussed mechanisms for the monitoring and evaluation of the IMCI community component at national, provincial, district and community level. Important principles were agreed.

12. Recommendations

To Member States

1. The existing high-level commitment to child health should be utilized and translated into action, such as through allocation of resources and stabilization of experienced staff, in order to accelerate scaling-up of IMCI implementation to achieve the MDGs.
2. Countries which are already reporting on IMCI progress on a quarterly basis should continue with the same pattern. Other countries should submit progress reports to the Regional Office (reports on IMCI activities, including community component) on a six-monthly basis. EMRO will prepare and distribute a reporting form for this purpose.

3. Countries should finalize their plans of action for the IMCI community component for 2006 and share them with the Regional Office by mid September 2005.

To Member States, WHO and partners

4. The rich experiences in countries of the Region should be properly documented, lessons learnt summarized and best practices widely disseminated through the different channels. For this to happen, countries should document their experiences and share them with WHO and other partners, who should support efforts in this regard.
5. National IMCI programme managers, WHO and UNICEF should foster and facilitate multisectoral partnership, at national and global levels, to accelerate country action. Civil society and nongovernmental organizations are critical stakeholders for expansion of the IMCI community component, and deliberate efforts should be made to engage and collaborate with these groups in the planning and implementation process.

To WHO

6. WHO, through the nature of its work with countries and partners (including UNICEF) at all levels, should continue to advocate for raising the profile of child health at all levels and mobilizing more support and resources for IMCI country implementation. Documentation of experiences is critical to provide information on progress that can then be used for advocacy.
7. WHO should continue to work with countries and partners and provide guidance at different stages of IMCI planning and implementation. More specifically:
 - WHO should accelerate the development of appropriate standard guidelines and tools to support IMCI community component implementation. There is need for generic training materials to train community health workers/promoters in home care.
 - WHO should continue to support countries in strengthening the knowledge and skills of focal persons involved in IMCI at different levels to plan, implement, monitor and evaluate the IMCI community component in their countries.
 - Support for capacity-building should also focus on skills for research proposal development, advocacy, behavioural change,

development of messages for communication and field-testing of communication materials, resource mobilization skills, etc.

8. The Regional Office should establish an e-discussion group with participants of the workshop to finalize and agree upon a list of key IMCI indicators.
9. WHO should continue to organize similar meetings addressing different themes to meet specific country needs affecting implementation of IMCI.

Annex 1

Agenda

1. IMCI implementation progress in the Region: Achievements and lessons learnt
2. IMCI Community component progress in the Region: Achievements, constraints and possible solutions
3. Feasible interventions to promote the proposed key family practices:
Sudan experience on child health community-based interventions
Oman experience on child health community-based interventions
4. Communication strategy: Definition, components, design process
5. Development of country plans of action
6. WHO role in supporting and monitoring the implementation of the community component
7. WHO and country role in monitoring the IMCI process and outcome indicators
8. Regular country reporting on IMCI progress to EMRO: mechanism
9. Technical updates
10. Closing session

Annex 2

Programme

Day 1: Sunday, 24 July 2005

08:00 –09:00	Registration
09:00 –11:00	Opening session: <ul style="list-style-type: none"> - Welcome remarks by Dr Ahmad Reza Joudat, Chancellor of Tabriz University of Medical Sciences - Welcome remarks by H.E. Dr Mohamed Ali Sobhanallai, Governor General of East Azerbaijan Province - Address by Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean - Speech of H.E. Dr Masoud Pezeshkian, Minister of Health and Medical Education, Islamic Republic of Iran - Introduction of participants - Adoption of Agenda - Progress of IMCI implementation in the Region (Dr S. Farhoud, Regional Adviser, CAH/EMRO)
11:00 –12:00	Progress of the IMCI community component in the Region: lessons learnt (Dr S. Farhoud, Regional Adviser, CAH/EMRO)
12:00 –15:00	Group work (1) : Moving forward the IMCI community component
15:00 –16:00	Plenary session: Group work presentations
16:00 –16:30	Discussion

Day 2: Monday, 25 July 2005

09:00 –09:10	Key family practices: Review of the evidence (Dr S. Pièche, CAH/EMRO)
09:10 –09:30	Promotion of key family practices: prioritization and plans to address identified priorities (Dr S. Farhoud, Regional Adviser, CAH/EMRO)
09:30 –09:40	Introduction to the communication strategy: definition, components, design process (Dr S. Pièche, CAH/EMRO)
09:40 –11:00	Group work (2.1): Communication design process – 1st step: Situation analysis and selection of audience and behaviours
11:00 –11:15	Wrap up on the first step of the communication design process (Dr S. Pièche, CAH/EMRO)
11:15 –12:15	Group work (2.2): Communication design process – 2nd and 3rd steps: Plan and develop materials

12:15 –12:30	Wrap up on the 2nd and 3rd steps and completion of the communication design process—4. Test and revise materials, 5. Implement and Monitor, and 6. Evaluate and Revise (Dr S. Pièche, CAH/EMRO)
12:30 –14:00	Country experiences on interventions to promote the recommended key family practices: Sudan: Community volunteers and mass media Oman: Social marketing for under five child health
14:00 – 5:30	Group work (3): Critical review of the Sudan and Oman country experiences
15:30 –16:00	Plenary session: Group work presentations

Day 3: Tuesday, 26 July 2005

09:00 – 4:30	Group work (4): Development of country plan of action to promote a priority key family practice
14:30 –15:30	Discussion on the WHO role in supporting the implementation of the community component country plans
15:30 –18:30	Marketplace

Day 4: -Wednesday, 27 July 2005

09:00 –10:00	Group work (5): Collecting and reporting information on key IMCI indicators
10:00 –11:30	Plenary session: Group work presentations and discussion Consensus on reporting mechanisms on IMCI indicators in the Region
11:30 –12:30	Technical updates: - Technical updates on the IMCI guidelines (Dr B. Daelmans, CAH/HQ) - Update on recent developments in the area of child health (Dr S. Aboubaker, CAH/HQ) - Updates on EMRO developmental work (Dr S. Farhoud, Regional Adviser, CAH/EMRO) - Update on research on the management of poisoning and burns in under-five children at PHC level (Dr S. Pièche, CAH/EMRO) - The CAH/EMRO website (Dr S. Pièche, CAH/EMRO)
12:30 –14:30	Discussion
14:30 –15:30	Closing session: Conclusions and Recommendations

Annex 3

List of participants

AFGHANISTAN

Dr Syed Nasir Hashimi
IMCI Community Component Medical Officer
IMCI Department
Ministry of Public Health
Kabul

DJIBOUTI

Mr Abdallah Hade
IMCI Focal Point
Ministry of Health
Djibouti

Dr Moktar Omar Ahmed
Office of Social Protection
Ministry of Health
Djibouti

EGYPT

Dr Mona Ali Rakha
National IMCI Coordinator
Director General of the Childhood Illness Programme General
Administration
Ministry of Health and Population
Cairo

Dr Samir Abdo El Naggar
IMCI Community Component Focal Point
Ministry of Health and Population
Cairo

Dr Azza Ahmed Abou Zeid
IMCI Coordinator
Director of MCH Department
Directorate of Health
Alexandria

IRAQ

Dr Suroor Mahdi Latif
MCH Director
Baghdad Health Directorate, Rassafa
Ministry of Health
Baghdad

Dr Nazhat Najim
IMCI Focal Point
MCH Director
Basrah Health Directorate
Ministry of Health
Baghdad

ISLAMIC REPUBLIC OF IRAN

Dr Hamidreza Lornejad
IMCI Focal Point
Ministry of Health and Medical Education
Teheran

Dr Khalil Farivar
Associate Professor of Paediatrics
Children Office of Deputy of Health
Ministry of Health and Medical Education
Teheran

JORDAN

Dr Nadia Abu Sabrah
Head of IMCI Division and
Assistant Director
Department of Chest Diseases
Ministry of Health
Amman

MOROCCO

Dr Aziza Lyaghfour
National IMCI Focal Point
Directorate of Population
Ministry of Health
Rabat

Dr Abderrahman El Aidi
Head Manager of Provincial Sanitary
Provincial Delegation of the Ministry of Health
Rabat

OMAN

Mr Ahmed Al Khonji
Director General, Health Services
Muscat Region
Ministry of Health
Muscat

Dr Fannah Abdullah Al Arai
IMCI National Focal Point
Director of Wilayat Health Services, Muttrah
Ministry of Health
Muscat

Dr Samira Moosa Al Maimani
Senior Specialist (FAMCO)
Ma'bel Health Centre
Ministry of Health
Muscat

Mrs Jokha M. Al Farsi
Head of Health Educators
Directorate General, Health Services
Muscat Region
Ministry of Health
Muscat

OCCUPIED PALESTINIAN TERRITORIES

Dr Younis Awadallah
Director and National Coordinator of IMCI
Gaza

PAKISTAN

Dr Zareefuddin Khan
Focal Point for IMCI Community Component
Deputy National Coordinator, Lady Health Worker Programme
Federal Ministry of Health
Islamabad

Dr Naila Sarfaraz
Deputy Provincial Coordinator
Provincial Focal Point, IMCI project in Punjab
Punjab

SUDAN

Dr Mohamed Ali Elabassi
Director General Primary Health Care
Chairperson, Child Health Policy (CHP) Task Force
Federal Ministry of Health
Khartoum

Dr Igbal Ahmed El Bashir
National IMCI Team and Child Health Policy (CHP) Task Force
Federal Ministry of Health
Khartoum

Dr Hanan Mukhtar Elhajabdou
National IMCI Focal Point
Federal Ministry of Health
Khartoum

Dr Rania Abdelmonim Sharawy
IMCI Community Component Focal Point
Federal Ministry of Health
Khartoum

SYRIAN ARAB REPUBLIC

Dr Hind Al Sayed
National IMCI Focal Point
Ministry of Health
Damascus

Dr Amer Sultan
IMCI Coordinator
Hama Health Directorate
Ministry of Health
Damascus

TUNISIA

Dr Mounira Garbouj
Director, Primary Health Care
National IMCI Focal Point
Ministry of Public Health
Tunis

Dr Ridha Djebeni
National IMCI Coordinator
Ministry of Public Health
Tunis

Dr Abid Faouzi
IMCI Focal Point
Health Education Manager
Primary Health Care Directorate
Ministry of Public Health
Tunis

YEMEN

Dr Abdulhabib Abdulrub Bashr
In charge of Training, IMCI Programme
Ministry of Public Health and Population
Sana'a

Dr Abdulla Al-Dhalae
Deputy Director
Child Health Programme
IMCI Community Component Focal Point
Ministry of Public Health and Population
Sana'a

Other organizations

AGHA KHAN DEVELOPMENT NETWORK/SYRIAN ARAB REPUBLIC

Dr Maher Aboumayaleh
Manager of Health Programme
Damascus

UNITED NATIONS CHILDREN'S FUND (UNICEF)

Dr Magdy El-Sanady
Health and Nutrition Officer
Cairo
EGYPT

Mr Seyed Enayatollah Asaei
Officer for the Integrated Early Childhood Development
Teheran
ISLAMIC REPUBLIC OF IRAN

Dr Maha Shadid
Project Officer
Community Empowerment
Amman
JORDAN

Ms Muna Bushnaq
Programme Assistant
Integrated Early Childhood Development (IECD) Protection
Amman
JORDAN

Dr Amel Ben Said
Programme Officer, Health
Tunis
TUNISIA

WHO Secretariat

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern
Mediterranean
Dr Mubashar R. Sheikh, WHO Representative, Islamic Republic of Iran
Dr Ahmad Mohit, Director, Health Protection and Promotion,
WHO/EMRO
Dr Suzanne Farhoud, Regional Adviser, Child and Adolescent Health
and Development, WHO/EMRO

Dr Sergio Pièche, Medical Officer, Child and Adolescent Health and Development, WHO/EMRO
Dr Bernadette Daelmans, Medical Officer, Child and Adolescent Health and Development, WHO/HQ
Dr Samira Aboubaker, Child and Adolescent Health and Development Medical Officer, WHO/HQ
Dr Ali Mafi, Medical Officer, WHO Islamic Republic of Iran
Ms Parisa Ardami, Programme Assistant, WHO Islamic Republic of Iran
Dr Ahmed Nagaty Abdel Moneim, IMCI Officer (SSA/IMCI), WHO Egypt
Dr Ahmed Shadoul, Medical Officer, Child and Adolescent Health and Development, WHO Pakistan
Mr Ahmed El Arousy, National Professional Officer (Desktop & User Support), WHO/EMRO
Ms Suzan El Raey, Senior Administrative Clerk, WHO/EMRO
Ms Yasmina Ibrahim, Secretary, WHO/EMRO

Annex 4

Key family practices in child care⁹

1. **EXCLUSIVE BREASTFEEDING.** Breastfeed infants exclusively for up to 6 months¹⁰. (Mothers found to be HIV positive require counselling about possible alternatives to breastfeeding)
2. **COMPLEMENTARY FEEDING.** Starting at about 6 months of age, feed children freshly prepared energy and nutrient rich complementary foods, while continuing to breastfeed up to two years or longer.
3. **MICRONUTRIENTS.** Ensure that children receive adequate amounts of micronutrients (vitamin A and iron, in particular), either in their diet or through supplementation.
4. **HYGIENE.** Dispose of faeces, including children's faeces, safely and wash hands after defecation before preparing meals and before feeding children.
5. **IMMUNIZATION.** Take children as scheduled to complete a full course of immunizations (BCG, DPT, OPV and measles) before their first birthday.
6. **MALARIA: USE OF BEDNETS.** Protect children in malaria-endemic areas, by ensuring that they sleep under insecticide-treated bednets.
7. **PSYCHOSOCIAL DEVELOPMENT.** Promote mental and social development by responding to a child's needs for care and through talking, playing and providing a stimulating environment.
8. **HOME CARE FOR ILLNESS.** Continue to feed and offer more fluids, including breastmilk, to children when they are sick.

⁹ *Improving family and community practices: a component of the IMCI strategy.* Geneva, World Health Organization, 1998. (WHO/CAH/98.2)

¹⁰ The current WHO recommendation is to breastfeed exclusively up to 6 months, with introduction of nutritionally adequate, safe and appropriate complementary foods and continued breastfeeding thereafter (*The optimal duration of exclusive breastfeeding – Results of a WHO systematic review*, WHO Geneva 28–30 March 2001). This recommendation was endorsed by the Forty-Seventh Session of the Regional Committee for the Eastern Mediterranean in resolution EM/RC47/R.10 (2000).

9. **INFECTIONS.** Give sick children appropriate home treatment for infections.
10. **CARE-SEEKING.** Recognize when sick children need treatment outside the home and seek care from appropriate providers.
11. **COMPLIANCE WITH ADVICE.** Follow the health worker's advice about treatment, follow-up and referral.
12. **ANTENATAL CARE.** Ensure that every pregnant woman has adequate antenatal care. (This includes having at least four antenatal visits with an appropriate health care provider and receiving the recommended doses of the tetanus toxoid vaccination. The mother also needs support from her family and community in seeking care at the time of delivery and during the postpartum and lactation period).

In the International Workshop on improving children's health and nutrition in communities, held in Durban, South Africa, 20–23 June 2000, these 12 practices were endorsed and four additional practices proposed. These practices need to be further defined and reviewed and relate to the following areas: HIV/AIDS prevention and care for sick orphans; active involvement of men in child care and reproductive health initiatives; prevention of child abuse and neglect, taking appropriate action when that occurs; and taking appropriate action to prevent and manage injuries and accidents.

To provide the type of care highlighted in the above list, families need:

- Knowledge about what to do;
- Skills to provide appropriate care;
- Motivation to try and sustain new practices; and
- Support for care, social and material needs from the community and the health system.

More information is available on the CAH/EMRO website at:
<http://www.emro.who.int/cah/CommunityComponent-Familypractice.htm#Section2>

INTERCOUNTRY WORKSHOP ON

IMCI

COMMUNITY COMPONENT

TABRIZ, ISLAMIC REPUBLIC OF IRAN
24-27 JULY 2005



For further information please contact:
Child and Adolescent Health and Development Unit
Regional Office for the Eastern Mediterranean, World Health Organization
Abdul Razzak Al Sanhoury Street, Cairo 11371, Egypt
Tel +20-2-670-2535 . Fax +20-2-670 2492/4 . E-mail: CAH@emro.who.int
<http://www.emro.who.int/cah>