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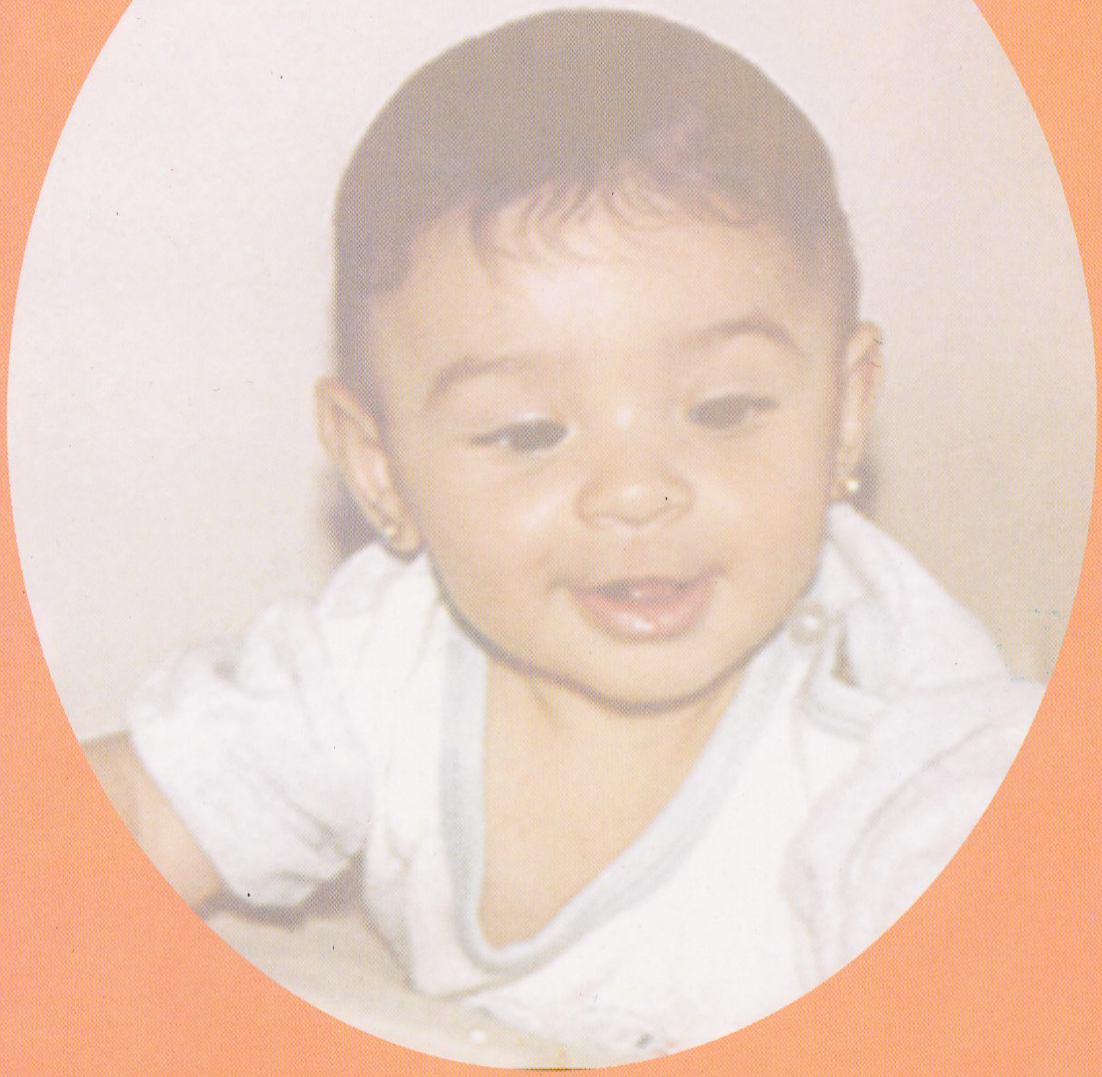
Framework for the community component of the integrated child care strategy



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Contents

Foreword

The integrated management of childhood illness (IMCI) strategy was developed jointly by WHO and UNICEF to reduce mortality and morbidity in children under 5 years of age and improve children's growth and development. This strategy represents a major shift from the previous programme-oriented approach, which focused on individual illness, to a more integrated approach that focuses on the whole child and the environment in which the child is born and develops.

The strategy consists of three main components, aimed at: 1) upgrading health providers' clinical and counselling skills; 2) strengthening health systems; and 3) improving family and community child care practices. Initially, the strategy focused on the first two components. Gradually, more attention is being given to fully integrated child care, addressing health, growth and development of all children, sick and healthy, in health care facilities and in the home. Emphasis is being placed on promoting good child care practices at home and in the community.

The family and the community where children live play a major role in child development. The community component of the IMCI strategy aims at improving family child care practices. There is longstanding need to involve the family and community actively and plan and implement child care interventions in both the health system and the community in parallel. While many interventions and projects exist at community level which concern child health, there has been some delay in countries in integrating such interventions into a comprehensive child care strategy that includes a well developed community approach.

This document proposes a framework for integrated community child care to guide national public health managers in planning community actions in the context of the IMCI strategy. While developing it, attention has been paid to the situation and needs of countries covered by the WHO Regional Office for the Eastern Mediterranean (EMRO). This framework is meant to be dynamic, incorporating specific country experiences as they become available.

Hussein A. Gezairy, M.D., F.R.C.S.
Regional Director for the Eastern Mediterranean

Preface

Development of the framework

The community framework for integrated child care (IMCI) developed by the Child and Adolescent Health and Development (CAH) unit of the WHO Eastern Mediterranean Regional Office (EMRO), is mainly based on discussions and recommendations from the joint WHO/UNICEF IMCI Regional Consultation held in Alexandria, Egypt, in November 2000[1] and the Intercountry Meeting on IMCI Documentation and Community Component held in Lattakia, Syrian Arab Republic, in October 2001. Further input came from discussions and preparations for the IMCI community component held during visits to countries in the Eastern Mediterranean Region, as well as previous country community experiences. The Framework proposes an approach to guide planning and implementation of the community component of the IMCI strategy.

In January 2001, a meeting organized by the Child Survival Collaboration and Resources (CORE) Group and BASICS II in Baltimore, Maryland, USA developed the *Household and Community IMCI Implementation Framework*, which identified many of the same key areas identified earlier in the Alexandria consultation. This provides further support for the EMRO framework, as its elements are being proposed as key elements in other regions as well. In presenting this regional framework, an effort has been made to use terminology similar to that used in the CORE meeting in order to facilitate the future development of a global strategy. Also taken into consideration in the preparation of this framework was the draft manual *Assessing and utilizing community and social support systems in health maintenance and treatment of illness of infants and young children*, by Stephen L. Schensul, Martha J. Bojko and Colleen Foster-Bey (Center for International Community Health Studies, University of Connecticut School of Medicine, United States of America).

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[1] *Report of the regional consultation on integrated management of childhood illness (IMCI), Alexandria, Egypt, 19-23 November 2000*. Cairo, WHO Regional Office for the Eastern Mediterranean 2001.(WHO-EM/CDD/086/E/L)

FRAMEWORK FOR THE COMMUNITY COMPONENT OF THE INTEGRATED CHILD CARE STRATEGY (IMCI)

Overview

The framework presented in these pages comprises two main elements: the foundation on which the community component must rely; and the planning process, consisting of planning steps, capacity-building, thorough situation analysis and development of the plan.

The foundation of the framework is partnership, at both central and implementation levels. To aid the planning process at these levels, a list of planning steps is provided, and details on the various steps are included in the framework.

A comprehensive plan for the integrated community child care strategy consists of five specific elements and follows a number of planning principles. Specific elements of a community child care strategy are the key features that together specifically characterize the IMCI approach versus traditional community interventions. Planning principles are essential principles to be considered when planning for the community component.

A section on indicators and targets is included to provide practical information for planning, with examples of the "flow of indicators" in a plan. Finally, a list of key child care family practices is shown in Annex 1.

Foundation

The planning process should bring together representatives of various departments and programmes within the ministry of health—*sector-wide partnership*—with academic institutions and other partners interested in or supporting community interventions in the country concerned (other ministries as appropriate, nongovernmental organizations and the private sector, international organizations)—*multisectoral partnership*. A similar structure should be created at implementation level (district and community), with a mechanism to share information and keep all partners updated. The concept of the IMCI Working Group on the Community Component is well in line with this approach. This sector-wide and multisectoral partnership at central and implementation level is a unique feature of IMCI as a strategy, in contrast with the traditional "programme" approach. IMCI would therefore serve as a key opportunity to coordinate child health-related interventions and rely on a wide range of community experiences.

The foundation of the framework is *partnership*, at both central and implementation levels...

Planning process

Overview

The planning process is summarized in Figures 1 and 2 in the form of ten steps to be carried out at central and implementation levels, respectively. The steps refer to specific elements of the framework that are described in detail in the sections that follow. It is

suggested that the central level provide support to the implementation level through on-the-job capacity building for planning.

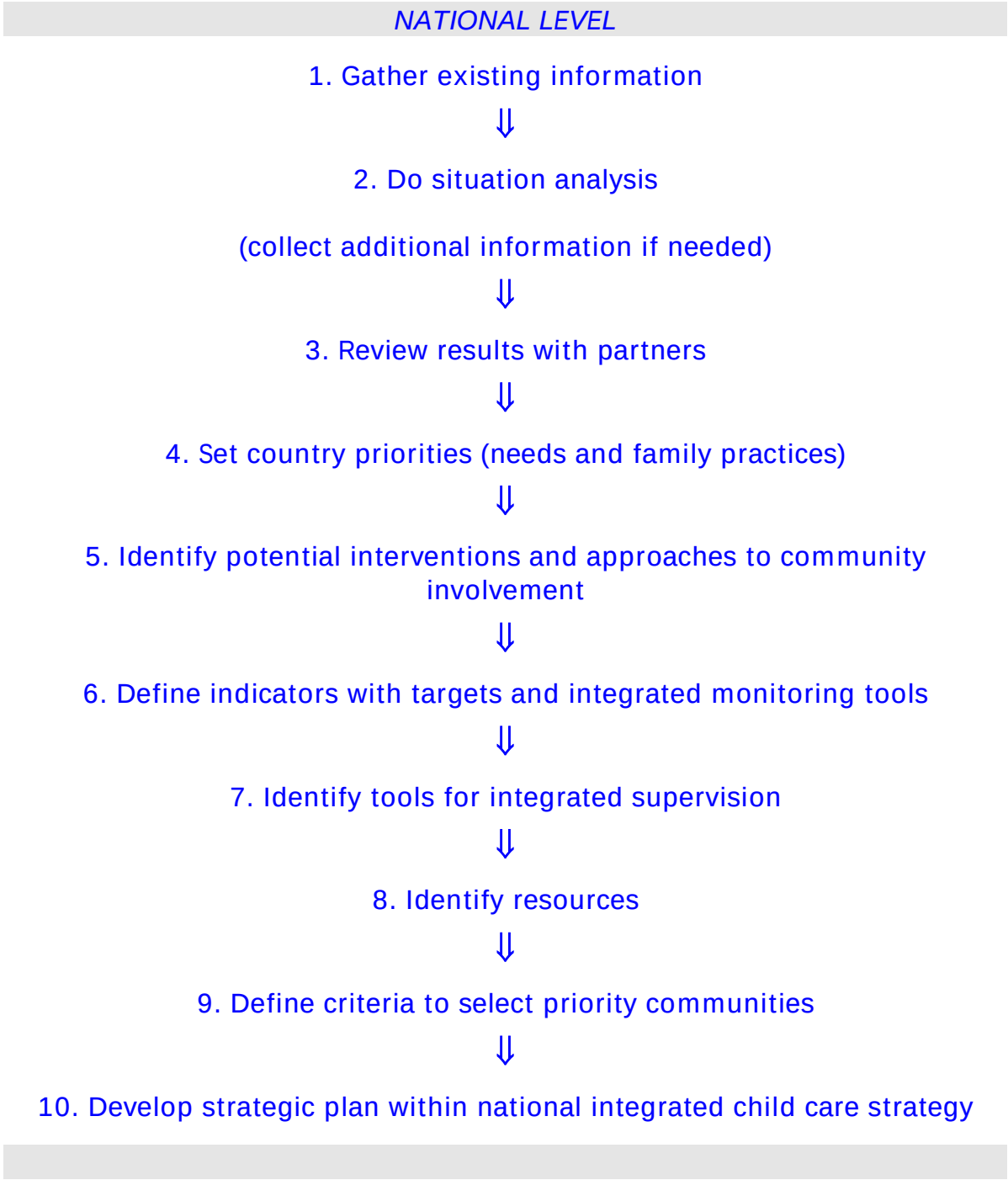

FIGURE 1. Planning process at central level

GOVERNORATE AND DISTRICT LEVEL

(with support from central level through on-the-job capacity building)

1. Do situation analysis

Interview key informants, do site visits and collect additional information if needed

⇓

2. Review results with partners

⇓

3. Select priority communities

(based on country criteria)

⇓

4. Identify local coordinators *

⇓

5. Set priorities (needs and family practices) *

⇓

6. Select the intervention and define objectives *

⇓

7. Select the approach to community involvement *

⇓

8. Identify resources *

⇓

9. Develop detailed operational plan with indicators and targets and integrate it into the overall district annual plan *

⇓

10. Obtain endorsement and commitment from local government, communities and partners *

* (With community participation)

FIGURE 2. Planning process at implementation level

Capacity-building at district level

Interventions are implemented and managed at community level; therefore, it is crucial that the capacity of the district IMCI team for planning and managing is developed and local coordinators are supported, with full involvement of local governments and nongovernmental organizations. However, any approach followed should be feasible on a large scale in order to be reproducible and applicable to new areas in the country.

Situation analysis

The situation analysis aims to select effective interventions using a "priority approach" based on *priority* needs in *priority* communities and population groups in areas where the IMCI strategy is being implemented, building on existing country-specific community approaches. It is an essential step in the planning process. Efforts should begin with gathering existing information from the country. After the analysis has been made, results should be shared and discussed with partners. The situation analysis is conducted first at central level and then at implementation level. Components of the situation analysis include the following activities.

The situation analysis is an essential step in the planning process

- Review of available information on key family child care practices in areas where the IMCI strategy is to be implemented, based on 12 key practices listed in Annex 1.

- Review of priority needs to improve both curative and preventive aspects of child care at community level, using the list of 12 key family practices as a reference. The priorities of individuals ("felt needs") should also be considered when defining the goals of the intervention, so that a linkage exists between the two.

- Review of existing interventions at community level and lessons learnt. These experiences are a very useful input as they are country-specific and therefore reflect the real situation in the field. As much as possible, the review should be based on available structured, standardized assessments of such interventions[2], in addition to qualitative information. Any monitoring instruments used in the interventions, and experience in their use, should also be reviewed.

- Review of existing health education and communication materials and activities, to ensure consistency of messages and coordination of interventions.

- Review of existing, successful approaches to involving communities in the country and the applicability and feasibility of using such approaches on a large scale.

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[2] E.g. formal assessments using standard forms and methodology such as surveys, standard follow-up visits conducted by trained staff, reviews of data on key indicators recorded and reported during the intervention, etc. Prudence should be exercised when reviewing interventions that do not have measurable indicators or objective information or reliable data on them, to identify those areas for which additional or more reliable information may be required.

- Review of data on caretaker satisfaction about services provided in health facilities where the IMCI strategy is being implemented. Caretakers' positive perception of the quality of services and how services address their "felt needs" can help to establish a relationship of trust between the community and the health system and later involve the community in child care interventions.

- Review of information on health provider satisfaction, including existing motivational schemes such as performance and commitment awards, certificates, participation in training courses and attendance at meetings.

- Identification of existing or potential community structures and channels to link the community and health system.

- Identification of information gaps and collection of additional information if needed for decision-making and planning (e.g. community assessment).

Development of a comprehensive plan for community child care

The IMCI strategy should serve as a catalyst to bring together partners, community projects and initiatives to develop a comprehensive plan and serve as a forum to coordinate child care-related activities at community level. It is expected that community-related activities will be implemented in the areas where the other two components of the IMCI strategy, related to the health system, are also implemented.

Planning by the IMCI community working group should take into consideration two issues in particular: a) key elements specific to IMCI, and b) essential planning principles.

There are five key elements of the integrated community child care strategy that together are specific to IMCI

a) Specific elements

EMRO has identified five key elements of the integrated community child care strategy that together specifically characterize the IMCI approach versus traditional community interventions. These elements, described below, are therefore defined in this framework as "specific elements".

ELEMENT 1. Selecting priority communities

Priority communities should be selected for implementation, that is, communities or population groups in which the risk of illness and/or death is higher than the general population and sub-optimal family behaviours related to the key child care practices put children at higher risk of illness. Criteria for selection should be developed beforehand, based on certain key indicators and a number of facilitating factors.

- Criteria based on key indicators. Examples include:

- health indicators (e.g. infant mortality rate; child morbidity for selected illness or conditions such as diarrhoea, malaria; maternal mortality ratio; low birth weight rate, low weight for age and other anthropometric and clinical indicators of malnutrition; immunization coverage, including also tetanus toxoid coverage for pregnant women) and access to health services and safe drinking-water;

- economic indicators (e.g. income);

- education level indicators (e.g. literacy);

- demographic indicators (e.g., population density and size, age structure). These and the above indicators would help describe communities from a broader health perspective and identify those most in need and whose children would benefit most from such interventions;

- community and district commitment and ownership indicators. These should also be considered to denote local support as pre-requisite for implementation and sustainability (e.g., local development committee existing and with a prominent health component; IMCI community plan included in overall annual district plan; allocation of local resources for its implementation; advocacy activities for child health included in the plan; etc).

Commitment and ownership indicators reflect local support, a prerequisite for implementation and sustainability

- Criteria based on facilitating factors. There are factors that can facilitate the implementation of an intervention and can be considered in addition to but not replacing the key criteria described above. They include the existence of successful community interventions (see Elements 2, 4 and 5) and structures linking the health system to the community (see Element 3), active partners (government and nongovernmental organizations), available resources, access to supervision, etc.

ELEMENT 2. Building on existing community interventions

Efforts should be made not to create a new project, but rather to build on the country-specific experience of existing community interventions and organizational structures. Examples of valuable experiences to consider are those related to:

- Establishment and existence of successful and functional partnerships with nongovernmental organizations and other programmes (immunization, nutrition, malaria, essential drugs, health insurance, etc.);

Efforts should build on the experience of existing community interventions

- Development of viable approaches to involve communities actively;

- Existence of effective health education and communication strategies and activities;

- Availability of project human and financial resources;

- Community-based health providers or community-oriented outreach services;

- Interventions improving care-seeking practices, establishing active breast-feeding support groups, etc.

ELEMENT 3. Linking the health system to the community

...from the health system to the community AND from the community to the health system

One of the characteristics of the IMCI strategy is that it targets both the health system and the community. An important element of the IMCI community component is therefore the establishment of key links between community initiatives and the health system, to ensure a continuum of care and full participation of the community in child care in a two-way approach: from the health system to the community and from the community to the health system. An examples of effective linkage includes the presence of all the following:

- Effective face-to-face communication during health facility encounters;

- Promotion of services, taking into account how quality of services is perceived by the community they serve and involving the community in ensuring service quality;

- Follow up and supervision of community-based care providers by health facility-based staff;

- Provision of feedback from the health facility to the community and from the community to the health facility on progress and outcomes of care for children at higher risk of illness.

ELEMENT 4. Improving access to quality child care by health providers

Health providers, whether facility-based, outreach or community-based, government or volunteer, play an important role in providing child care and educating the community on child care and development. As such, they represent an important element of the IMCI community component for both curative (treatment, counselling and referral) and promotional aspects of child care. Understanding community care-seeking behaviour is essential for the development of strategies to maximize the function of community-based providers and linking outreach services to the community. Training approaches should follow the same quality approach used for other IMCI training, e.g. rely on quality training criteria, training of trainers, skill reinforcement and follow-up of trainees.

ELEMENT 5. Promoting key family practices for child care

The integrated child care strategy includes both care during illness and care for healthy growth and development of children. The list of 12 key family child care practices should guide the selection of practices to be initially promoted within the context of the integrated child care strategy. Stimulating child psychosocial development and promoting

health are activities that apply to all communities, not only to those where infant mortality levels have fallen below 40 deaths per 1000 live births[3]. Practices are related to behaviours and the promotion of the desired behaviours require systematic planning, well coordinated use of a combination of channels of communication, close follow-up, monitoring and supervision. This element of intervention needs to go beyond knowledge acquisition to facilitate changes in behaviour. Behavioural changes occur over a relatively long period of time and need to be sustained throughout that period: adequate resources must therefore be identified within and outside the community to support the intervention in the long term. The more actively the community is involved and participates in the intervention, the higher the possibility that the intervention will be sustainable and result in the desired outcome.

b) Planning principles

Planning principles are essential principles that should always be considered when planning for the community component. The plan and strategy for community integrated child care should:

- Be logically and operationally linked with and be part of the country overall IMCI strategy and directional plan;
- Rely on a thorough situation analysis;
- Use multiple approaches (‘multi-dimensional’) to target more than one causal factor;
- Include all steps to achieve clearly stated quantitative targets and sub-targets and describe tools and timetable to measure both *process* (what is done) and *outcome* (impact of intervention) indicators;
- Target the whole community, including both the population and health providers serving it in the same locality;
- Identify resources for initial implementation and mechanisms for long-term sustainability;
- Identify local coordinators and involve the community throughout the process;
- Periodically review priorities and experience in implementation through monitoring and evaluation, considering achievements, constraints and newly identified needs.

The role, responsibility and contribution of all those involved in related areas and projects should be clearly indicated in the plan, ensuring that links and coordination are strengthened between the different activities carried out by various partners at community level.

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[3] This threshold is proposed because the WHO/UNICEF generic IMCI clinical guidelines may significantly contribute to child survival in those areas with higher levels of infant mortality rate, where a substantial incidence of bacterial conditions (and risk factors such as malnutrition) that would respond to antibiotic therapy may be expected in children visiting first-level health facilities.

PLANNING: INDICATORS AND TARGETS

A programme indicator is basically a number, proportion, percentage or rate that suggests or "indicates" the extent to which planned activities have been conducted (*process* and *output indicators*) and programme achievements have been made (*outcome* and *impact indicators*)[4]. These two families of indicators, very broadly defined, are briefly described below[5]. The key message of this section is that plans should always include clear and measurable indicators that go beyond monitoring the "process" to include also the "outcome", that is what the intervention should lead to, in relation to the main reason why certain activities have originally been planned. For example, training courses may be planned on counselling on child care. This is done: → to improve health providers' counselling skills → to increase caretakers' knowledge of child care → to improve caretakers' child care practices (*outcome*) → to improve child health, e.g. reducing child deaths, illness or improving child growth and development (*impact*).

Plans should always include clear and measurable indicators that go beyond monitoring the *process* to include also the *outcome*

Process indicators refer to quantitative indicators selected to determine whether planned activities took place, e.g. holding of a meeting with NGOs, development and testing of health education materials or conduct of communication skills training courses for community volunteers. In this category one may include also *output* indicators, which are those adding more details in relation to the output of the activity, e.g. the number and categories of community health providers trained in communications skills, the number of printed materials or radio programmes for health education developed, the number and type of radio spots produced and broadcast. Indicators can also be selected to monitor the *quality* of the activities conducted according to a number of established quality criteria or standards.

> EXAMPLE. In the case of a training course on counselling, indicators to monitor the quality of training may refer to the ratio of facilitator to participant, percentage of total time spent practising the counselling skills and number of caretakers counselled per participant, proportion of participants trained that were followed up with skill reinforcement visits within 4 weeks of training, etc.

These indicators are useful management tools to monitor implementation: related targets should be set for them during the planning process and included in the plan. Targets must always be quantified: e.g., if the indicator is "proportion of community health volunteers trained in breastfeeding counselling", the target would be expressed as "50% of the community health volunteers in the districts implementing IMCI will have been trained in breastfeeding counselling by the end of 2003". These targets, however, are limited to aspects of quantity ("how much") and do not provide information on the result and impact of the activity. For this, another set of indicators is needed, "outcome" indicators.

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[4] Adapted from *CDD/ARI programme management, a training course: introduction*. Division of Diarrhoeal and Acute Respiratory Disease Control [CDR], Geneva, World Health Organization, 1995.

[5] Many types of indicators have been defined, including process, input, output, outcome and impact indicators. For the purpose of simplification and clarity, they have been grouped in this section into two main 'families' of indicators.

Outcome indicators[6] refer more specifically to the objectives of the intervention, that is its 'results', its outcome, the adoption of the recommended practice. These indicators indicate the reason why it was decided to conduct certain activities and are related to performance.

> EXAMPLE. If the reason for an intervention consisting of training health providers in IMCI is to improve the management of sick children under 5 years old, the outcome indicator in this case would then be expressed as "the proportion of trained community health volunteers who manage a sick child correctly according to the IMCI guidelines". If the objective of the intervention is to improve home care of sick children, an outcome indicator could be "the proportion of mothers who adequately care for ill children". If the objective is to improve child psychosocial development, an outcome indicator could be "the proportion of mothers who play and communicate effectively with their children".

These indicators, therefore, allow us to know whether the desired outcome has been generated. Targets for outcome indicators should be set and included in the plan. However, it takes time before final outcomes can be measured. A number of *intermediate outcome* indicators should therefore be identified—and related targets set—for all the intermediate changes that the intervention is expected to bring about and that will eventually lead to the final outcome, in order to help us know whether we are progressing towards achieving the expected outcome.

> EXAMPLE. If the objective is to improve child care practices in the home and the intervention is to train community health providers in counselling on child care, the first expected (intermediate) outcome could be "the proportion of trained health providers who properly and effectively counsel mothers on selected child care topics", before this in turn leads to improved knowledge of home care for sick children among the counselled mothers (another intermediate outcome) that should eventually result in improved home child care practices among the counselled mothers (final outcome).

It is obvious that the target set for the final outcome indicator should be based on the targets for the process indicators and intermediate outcome indicators. For instance, in the example above, let us assume that in the pre-intervention phase only 20% of mothers are found to have good knowledge of how to care for a sick child. If it is planned to train 30% of all health providers in a community in counselling on home care, it would be unrealistic to expect all (100%) mothers in the community to receive good counselling, to have good knowledge of home care and care for their children properly as a result of the training intervention.

These indicators, therefore, are of utmost importance. They should be monitored on a regular basis and plans for monitoring them should be included in the master plan for the intervention. Monitoring can include routine data collection, home visits, in-depth individual interviews, focus group discussions, observation of practices, intercept interviews, etc. It provides information not only about what is happening but also about why

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[6] Definitions of outcome indicators adapted from *Communication: a guide for managers of national diarrhoeal disease control programmes, planning, management and appraisal of communication activities*. Geneva, World Health Organization, 1987.

things are or are not happening. Monitoring of these indicators will tell us how the intervention needs to be modified during implementation. Communities should be involved in identifying solutions to the problems identified in the monitoring. An analysis of the progress towards achieving the targets set for these indicators will provide information valuable for the intervention and for future planning.

Three examples are provided in the next pages to illustrate the logical "flow of indicators" from process to outcome and impact. It is understood that more than one strategy is often needed to achieve a certain objective, especially if the objective concerns changes in family practices, and each strategy needs clear indicators and targets of its own. However, in the examples provided in the next pages, each example shows only one set of indicators per intervention, in order to illustrate the logic of the "flow" and keep the examples simple and straightforward.

Examples of "flow of indicators"

Example 1. Improving care of children under 5 years old with diarrhoea in the home through training of community health volunteers on child home care in district "Zed"

▸ **Objective**	To improve home care of children under 5 years old with diarrhoea in district Zed
▸ **Main strategy**	Counselling on child home care in the community
▸ **Intervention**	Training in counselling on child home care for community health volunteers in district Zed
Indicators (assumed chain of events)	
▸ **Process**	Number of training courses on counselling on child home care conducted for community health volunteers in district Zed
	⇓
▸ **Output**	Number of CHVs* trained in child home care
▸ **Outcome**	⇓
Intermediate	Proportion of trained CHVs* *properly and effectively*[7] counselling caretakers of sick children on child care
	⇓
Intermediate	Proportion of caretakers of children below five years old counselled by trained CHVs* who know how to care for a child with diarrhoea
	⇓
Final	Proportion of children below 5 years old with diarrhoea who receive *adequate*[8] care in the home in district Zed
	⇓
▸ **Impact**	Reduction in diarrhoea-associated mortality in children under 5 years old

*CHVs: Community health volunteers

For each indicator a target should be set, replacing the words "number" and "proportion" with a specific figure and indicating the time by which the target is to be achieved. For instance, the main target for the final outcome indicator in this example could be: "70% of children with diarrhoea will be receiving *adequate* care in the home in district Zed by the end of 2002".

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[7] *Properly and effectively*: e.g. giving the standard, correct messages using a range of appropriate communication methods as taught in the training course.

[8] *Adequate:* e.g. will be given increased fluids and continued feeding during the episode of diarrhoea.

Example 2. Improving exclusive breastfeeding practices for children less than 6 months old through training of community health workers in breastfeeding counselling in "Alzed" province

▸ **Objective**	To improve exclusive breastfeeding practices for children less than 6 months of age in Alzed province
▸ **Main strategy**	Counselling on breastfeeding in the community
▸ **Intervention**	Training in counselling on breastfeeding for community health workers in Alzed province
Indicators (assumed chain of events)	
▸ **Process**	Number of training courses on breastfeeding counselling conducted for community health workers in Alzed province
	⇓
▸ **Output**	Number of CHWs* trained in breastfeeding counselling in Alzed province
▸ **Outcome**	⇓
Intermediate	Proportion of trained CHWs* *properly and effectively*[7] counselling pregnant women and mothers on exclusive breastfeeding
	⇓
Intermediate	Proportion of pregnant women and mothers of children less than 6 months old counselled by trained CHWs* who know about exclusive breastfeeding
	⇓
Final	Proportion of children less than 6 months old who are exclusively breastfed
	⇓
▸ **Impact**	Reduction in infant mortality and diarrhoea morbidity

*CHWs: Community health workers

An example of a target for the final outcome indicator in this example could be: "45% of children will be exclusively breastfed up to 6 months in the province of Alzed by the end of 2003".

Example 3. Improving care-seeking practices for children under 5 years old with acute respiratory infections through radio campaign in Alzed province

▸ **Objective**	To improve care-seeking practices for children under 5 years old with acute respiratory infections (ARI) in Alzed province
▸ **Main strategy**	Communication campaign
▸ **Intervention**	Broadcasting of radio spots on care-seeking for children with cough or breathing problems in Alzed province
	Indicators (assumed chain of events)
▸ **Process**	Number and type of radio spots produced
	⇓
▸ **Output**	Number, type and schedule of radio spots broadcast
	⇓
▸ **Outcome**	Percentage of caretakers of children under 5 years old in Alzed province who have heard the radio spots (“*exposure indicator*”: measures how many people are exposed to the intervention)
	⇓
Intermediate	Percentage of caretakers of children under 5 in Alzed province who know about fast and difficult breathing as warning signs for pneumonia (“*knowledge indicator*”: measures how many people know about the message)
	⇓
Intermediate	Percentage of caretakers of children under 5 in Alzed province to whom the radio messages are acceptable, useful and feasible (This indicator measures the relevance and appropriateness of the message to the sociocultural context in which it is delivered)
▸ **Outcome**	⇓
Final	Proportion of caretakers of children under 5 years old with cough or breathing problems who have taken their children to a health provider because of fast or difficult breathing within 24 hours of its onset
	⇓
▸ **Impact**	Reduction in mortality in children under 5 years old

Annex 1

KEY FAMILY PRACTICES IN CHILD CARE[9]

1. EXCLUSIVE BREASTFEEDING. Breastfeed infants exclusively for up to 6 months[10]. (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. 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.

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[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).

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.