CAH reaching out

Child and Adolescent Health and Development

ISSUE No.3, May 2006

Events

FIFTY-NINTH WORLD HEALTH ASSEMBLY
Geneva, Switzerland
22-27 May 2006

Items involving CAH

11.3 Nutrition and HIV/AIDS (Documents EB117/2006/REC/1, resolution EB117.R2, and A59/7)

11.8 Infant and young child nutrition: quadrennial report (Document A59/13)

11.9 WHO's contribution to implementation of the strategy for child and adolescent health and development (Document A59/14)

11.17 Family and health in the context of the tenth anniversary of the International Year of the Family (resolution WHA57.11)

25th Anniversary of IYCF Code

The International Code of Marketing of Breast-milk Substitutes, also known as The Code, marks its 25th anniversary in 2006. Adopted by the World Health Assembly in May 1981, The Code is an international public health recommendation. WHO marks the 25th anniversary at the WHA in May. Member States have been asked to provide up-to-date information on the status of Code implementation. The results will form part of a special display at the Assembly. A document on frequently asked questions concerning the Code will be available.

DANIEL ARATANGY

COUNTDOWN TO 2015: slow progress towards MDG goal for Child Survival

Figures released at the Countdown to 2015 conference held in London at the end of last year reveal that coverage of key child survival interventions is low or very low in all of the 60 countries which account for 95% of child deaths.

The average rate of mortality reduction over the period 1990 - 2004 in these countries has only been 1.2%, while 8.4% would be required to achieve the Millennium Development Goal of a two-third reduction by 2015 of 1990 rates.

Coverage with a small set of key child survival interventions of mothers and children who need them is essential for reducing child mortality. In response to this urgent challenge, CAH has been working with the Bellagio Child Survival Group, UNICEF, and other partners to launch the Countdown to 2015 initiative, with the aim of improving the monitoring of progress in intervention coverage in countries.

The first Tracking Progress 2005 Report will be released in the second quarter of 2006, accompanied by an announcement in *the Lancet*. The global Countdown will follow a two-yearly reporting cycle. At the same time, WHO and UNICEF are committed to intensify their support to countries. This will involve monitoring programme implementation, through more frequent national surveys, the development and application of simpler district surveys, and close collaboration with the Health Metrics Network to strengthen national health information systems.

The first Countdown Conference is already yielding results. GAVI has committed to increased investments in health system strengthening in countries to accelerate the delivery of a broader range of child survival interventions. Discussions on how to make this work in practice are under way in Bangladesh and Ethiopia. The Government of Senegal is also planning a national Countdown initiative, and the Government of Mexico has expressed an interest in documenting and analysing its investments in child survival.

For more information on the Countdown to 2015 initiative and the first conference held in London, please consult www.childsurvivalcountdown.com.

Q&A

Dr Neena Raina

Regional Adviser
Adolescent Health and Development
WHO/SEARO

Dr Neena Raina is Regional Adviser, Adolescent Health and Development in WHO SEARO. She joined WHO in 1998 as a Technical Officer in Control of Diarrhoeal Diseases and Respiratory Infections. Most of Neena's professional life has been spent working in maternal and child health. Up until 2004 she worked with CAH on newborn and child health and IMCI. She is now working to push forward the agenda of adolescent health including HIV/AIDS among young people.

What are the three most important accomplishments on adolescent health in the South-East Asia region, over the last few years?

One very encouraging thing is the increase in the number of countries which have included adolescent health in their areas of work. In 2002-03 it was just two countries; now that has risen to nine today. This means a substantial commitment by the countries to adolescent health including budget. Secondly, we have been able to collate the epidemiological information and produce fact sheets for 11 countries. This material is very useful for advocacy to help countries focus on adolescent health problems in the region. Finally, we have been able to concentrate our approach in three main areas, the adolescent health strategy, adolescent friendly health services and HIV and young people.

What has helped and hindered your work?

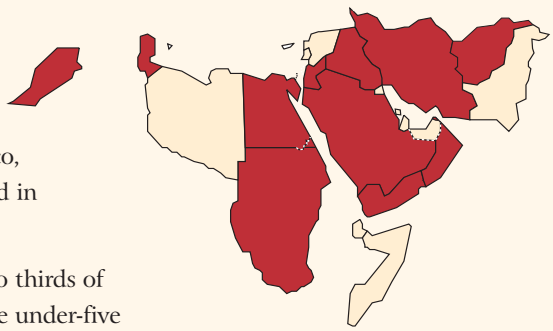
We have had excellent collaboration within WHO at all levels; country, regional and HQ. For example, with the HIV department to move forward the agenda on HIV and young people and also with our colleagues in Nutrition, Mental Health, Health Promotion and Reproductive Health. Also, the responsiveness of the ministries of health towards adolescent issues has given our work a tremendous boost. It has been especially helpful to have a dedicated programme person with the MOH. This collaboration is paying off at country level, in some cases literally, with Bangladesh receiving US$ 19 million from the Global Fund for work in HIV and young people, and US$ 1 billion under the Reproductive and Child Health (RCH II) programme in India, part of which will be spent on adolescent sexual and reproductive health.

The main challenge has to do with resources. As you know there is always competition for resources and I occasionally feel that the needs of adolescents are sometimes neglected. It's not just a question of money either, we need people as well. Today there are very few countries with a dedicated focal point for adolescent health in WHO country offices. The other challenge is to coordinate with other sectors such as education, youth and social justice, which is what WHO is not always doing. This is why partnerships with other agencies are so important.

You have worked for several years on child health. You are now working on adolescent health. What would you say are the similarities and differences in these two areas?

In some ways it is similar. I still work closely with colleagues in the Ministry of Health and UN partner agencies and the core function is the same - health care delivery. But I have discovered some huge differences. The first is awareness of the issue. Child care is very well known within the health system. But adolescent health can almost seem invisible at times. I think awareness of adolescent health needs is where child health was two and a half decades ago. Child health is also disease focused and ministries too tend to be disease and mortality oriented so they may not always appreciate the problems of young people. And the final big difference is that there is no one specialized degree for adolescent health. In child health there are many paediatricians but young people require a mix of specialities ranging from paediatricians, obstetricians and gynaecologists and public health specialists. We have already begun collaborating with professional associations of paediatrics and obstetrics and gynaecology and I see this as a very stimulating opportunity for the future.

Encouraging news on IMCI coverage in the Eastern Mediterranean Region



New data from Afghanistan, Egypt, Islamic Republic of Iran, Iraq, Jordan, Morocco, Oman, Saudi Arabia, Sudan, Tunisia and Yemen shows an encouraging upward trend in IMCI coverage in the Region.

The rapid adoption of IMCI in Afghanistan reached a third of health facilities in two thirds of districts in the country. Egypt is on track with its ambitious target to cover the whole under-five population in the country by the end of 2007: two thirds of health facilities were reached, covering an estimated three quarters of the target population. The Islamic Republic of Iran also reported a high IMCI coverage of 95% of health facilities providing primary health care services to two thirds of under-five children.

IMCI training activities in Morocco increased substantially in 2005, with a fourth of health facilities reached, covering an estimated one third of the under-five population. More than two thirds of health facilities were covered in Oman by the locally adapted IMCI strategy. In Sudan, about half of all targeted health facilities were reported to have staff trained in IMCI. IMCI in Tunisia continued steadily, reaching 8% of primary health care facilities. Finally, IMCI training activities were reported to have reached a quarter of health facilities in Yemen.

Country focus - Tanzania

Dramatic growth in coverage of IMCI in Tanzania

In five years Tanzania has achieved a remarkable turnaround in the coverage of IMCI - Integrated Management of Childhood Illness. Its implementation has risen from only 20 districts in 1999 to 107 districts at the end of last year - an increase of 435%.

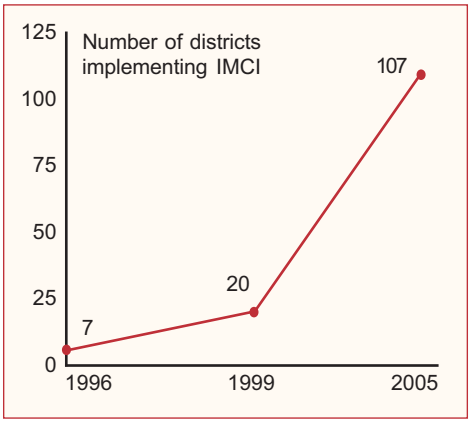
According to Dr Theopista John, CAH National Programme Officer in Tanzania, " The increased acceptance of IMCI has dramatically improved the quality of care for sick children. As a result, child survival rates are improving steadily as more children get better access to higher quality essential health services."

A recent multicountry evaluation of IMCI in Tanzania showed a 13% reduction in mortality as well as an improvement in nutritional status in under fives in districts implementing IMCI after two years. This represents 28,000 fewer child deaths per year in Tanzania. Overall child mortality has been reduced by 13%.

"We have also seen other benefits," says Dr John. " For example, measles immunization has increased to 97% and national ORS coverage has grown from 55% to over 70%".

The increased acceptance of an integrated approach to child health has also had considerable cost benefits for Tanzania. The cost of correctly managing a sick child is US$ 4 with IMCI compared to US$ 26 with routine care.

IMCI is an integrated strategy which acknowledges that children brought for medical treatment in the developing world often suffer from more than one condition. It aims at combining treatment of the major childhood illnesses, with an emphasis on prevention through immunization and improved nutrition.



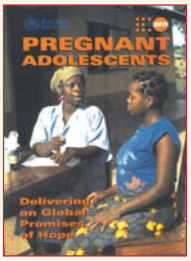
New publications

Developing the evidence-base - A review of programmatic actions titled: Adolescent pregnancy: Unmet needs and undone deeds

This exhaustive review of the literature and of programmes provides a solid evidence-base for policy-makers and programme managers to act upon, in ensuring that pregnancy in adolescents is both wanted and safe both to the mother and the child.

Developing tools for advocacy - Pregnant Adolescents: Delivering on global promises of hope

This document highlights the risks that adolescent girls face during pregnancy and childbirth. It then points to the scale of the problem and stresses that addressing it will have a direct bearing on the global community's achievement of the Millennium Development Goals 4 and 5. Finally, it outlines what could be done, *and needs to be done*, to making pregnancy safe in adolescents, and reducing mortality and morbidity among them.



Epidemiology and management of common skin diseases in children in developing countries

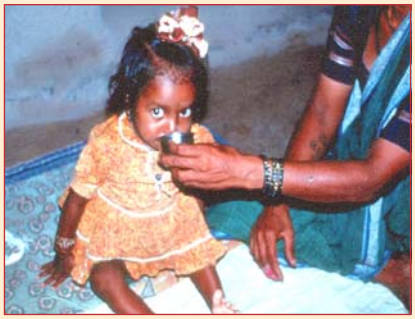
Despite the high frequency of skin diseases in developing countries, they have so far not been regarded as a significant health problem in the development of public health strategies. This review provides comprehensive data on the epidemiology of the commonest skin disorders in a developing country environment, documents their health importance, describes measures that could be used to control them, and permits a rational consideration of the problem. The review was performed with a view to future integration of matters relating to skin diseases in children with IMCI programmes, and discusses possible approaches.

Improved formula ORS

In 2004, WHO and UNICEF unveiled a new formula for the manufacture of Oral Rehydration Salts (ORS).

The latest improved ORS formula contains less glucose and sodium (245 mOsm/l compared with the previous 311 mOsm/l). The lower concentration of the new formula allows for quicker absorption of fluids, reducing the need for intravenous fluids and making it easier to treat children with acute non-cholera diarrhoea without hospitalization.

WHO and UNICEF recommend that countries now manufacture and use the new ORS in place of the previous formula. For this, WHO and UNICEF have published new guidelines and a revised monograph for the new ORS formula in the fourth edition of the International Pharmacopoeia to assist ORS manufacturers and countries in producing this new ORS formulation.



WHO

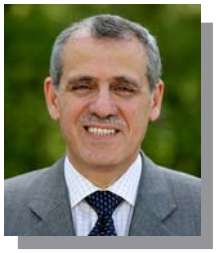
WHO and UNICEF will support national authorities to use the manufacturing guidelines and procedures for the new formula. Establishing the local production of ORS will be a key step to ensure countries can meet their own needs in controlling diarrhoeal disease.

To have the greatest impact on reducing diarrhoea mortality and malnutrition in children oral rehydration therapy should be combined with counselling to caretakers on appropriate feeding practices, including provision of zinc supplements (20 mg of zinc per day for 10 to 14 days) and continued breastfeeding during acute episodes of diarrhoea to protect against dehydration and reduced protein and calorie consumption. ■

OPINION

Dr Ala Din Alwan

Special Representative of Director-General, Health Action in Crisis



The tsunami that struck south-east Asia in 2005 was the biggest natural disaster on record. 180,000 people were killed and at least 50,000 people are still missing. The lives of hundreds of thousands of mothers and children were changed forever. In a matter of minutes they lost their homes, their families, their schools, their access to adequate food, water and sanitation, and health.

The current drought in the Horn of Africa is another good example. An estimated 15.5 million people are at risk for starvation and an estimated 8.3 million people in the area need emergency support. As always, the most vulnerable to psychosocial and physical health threats including malnutrition and disease are newborns and children under five years of age.

These are statistics from just two high profile disasters. Over the last decade, there have been dozens of other emergencies which have seriously affected children. However, much remains to be done to cater to the special needs of children. Sadly, their protection, treatment and care remain a secondary concern for the humanitarian community in an emergency.

Despite this dismal picture, there are success stories. After the devastation caused by the September 2005 earthquake in Pakistan, immunization rates against childhood diseases increased; by March 2006, almost 1.5 million children had been vaccinated against measles and polio. Indeed, services are reportedly of higher standard and more widespread than before the earthquake.

Yet, there is no doubt that children remain one of the most vulnerable groups in emergencies. We need to develop a more systematic approach to save lives and reduce suffering during emergencies. In more general terms, communities at risk should be encouraged to implement mitigation and preparedness programmes through sound planning processes. This is the only way to increase their readiness to respond efficiently and promptly to adverse events, to have an organized approach to minimize death and suffering and to cater for vulnerable groups such as newborns, children and their mothers. Failing to do so will result in much higher avoidable morbidity and mortality rates, especially among the most vulnerable, and will be a setback in development achievements that will take years and even decades to overcome.

Provision of routine disease prevention interventions for newborns and children should always be a priority, including during emergencies. This must include mothers and other care givers who ultimately determine the quality of care that children receive. Preparedness plans and strategies should include essential medical as well as survival interventions for the very young and vulnerable.

We know the most basic lesson from crises in the past three decades is that communities are the first respondents. Communities should be empowered to take action, even in times of crises. Health care services for newborns and children should be established in shelters and temporary refuges, with skilled staff implementing evidence-based interventions. ■

■ WHO statement on discontinued iron and zinc supplementation trials published

The two large community-based studies in Zanzibar and Nepal to evaluate the impact of zinc and iron plus folic acid supplementation on morbidity and mortality in young children were stopped following advice from the trial Data Safety Monitoring Board.

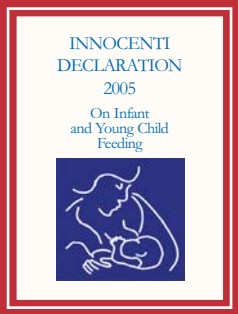
While confirming that iron supplementation is effective for reduction of iron deficiency and anaemia in iron deficient children, the trial in Zanzibar showed that under certain conditions supplementation may be associated with adverse effects, specifically increased risk of hospitalization (primarily due to malaria and infectious disease), and mortality.

The statement says that until the WHO recommendations are revised it is advised that iron and folic acid supplementation be targeted to those who are anaemic and at risk of iron deficiency. They should receive concurrent protection from malaria and other infectious diseases through prevention and effective case management.

The full statement is available at: www.who.int/child-adolescent-health/New_Publications/CHILD_HEALTH/WHO_statement_iron.pdf

■ 15th Anniversary of Innocenti Declaration

The 1990 Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding has celebrated its 15th birthday. The anniversary was a chance to renew commitment to breastfeeding and all aspects of improving infant and young child feeding. The event also sought to raise the profile of breastfeeding and all elements of infant and young child feeding as key interventions for improving child survival, growth and development, and to bring this once again to the attention of governments and donors.



A full report on the updated Innocenti Declaration can be found at www.unicef-icdc.org/publications/pdf/1990-2005-gb.pdf

Send your comments, suggestions and questions to **cah@who.int**

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