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CHILD SURVIVAL: A STRATEGY FOR THE AFRICAN REGION

Report of the Regional Director

EXECUTIVE SUMMARY

1. The past 20 years have witnessed improvements in child survival due to effective public health interventions and better economic and social performance worldwide. Nevertheless, about 10.6 million children die yearly, 4.6 million of these in the African Region. About one quarter of these deaths occur in the first month of life, over two thirds in the first seven days. The majority of under-five deaths are due to a small number of common, preventable and treatable conditions such as infections, malnutrition and neonatal conditions occurring singly or in combination.

2. The average decline in under-five mortality experienced globally over the years is mainly attributed to decline in rates in countries with rapid economic development. The African Region needs to increase its average annual mortality reduction rate to 8.2% per annum if Millennium Development Goal 4 is to be achieved by 2015. A number of affordable recommended interventions have been identified which could prevent 63% of current mortality.

3. The key to making progress towards attaining the goal by 2015 is reaching every newborn and child in every district with a limited set of priority interventions. New and serious commitments are necessary to prioritize and accelerate child survival efforts and allocate resources within countries.

4. Priority child survival interventions that will be implemented and scaled up include newborn care with a life-course approach and continuum of care; infant and young child feeding, including micronutrient supplementation and deworming; provision and promotion of maternal and childhood immunization and new vaccines; prevention of mother-to-child transmission of HIV; and using Integrated Management of Childhood Illness to manage common childhood illnesses and care for children exposed to or infected with HIV.

5. This document presents a strategy for optimal survival, growth and development of children 0–5 years of age and for reduction of neonatal and child mortality in the African Region in line with the Millennium Development Goals.

6. Governments will take the lead in ensuring an integrated and focused approach to programme planning and service delivery to scale up newborn and child health interventions. WHO and partners will support countries in this effort.

7. The Regional Committee is invited to review the proposed WHO, UNICEF and World Bank strategy and adopt it and the attached resolution for use by countries in the African Region.

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INTRODUCTION

1. Child survival, which refers to survival of children aged 0–5 years, is a major public health concern in most countries in Africa. The past 20 years have witnessed improvements in child survival due to effective public health interventions and better economic and social performance worldwide. Nevertheless, about 10.6 million children die yearly, 4.6 million of these in the African Region. About one quarter of these deaths occur in the first month of life, over two thirds in the first seven days. The majority of under-five deaths are due to a small number of common, preventable and treatable conditions.

2. In 2000, the nations of the world met and agreed to the Millennium Development Goals (MDGs). One of the targets is to reduce by two thirds between 1990 and 2015, the under-five mortality rate (MDG 4). A few countries have made progress, but overall, countries in sub-Saharan Africa are not on track to achieve MDG 4. The African Region needs to increase its average annual mortality reduction rate to 8.2% if MDG 4 is to be achieved by 2015.[1]

3. International treaties and conventions such as the Convention on the Rights of the Child (1990), the UN Special Session on Children (2002) and the WHO/UNICEF Global Consultation on Child and Adolescent Health and Development (2002) emphasize the inherent right to life and the urgency of reducing child mortality for future prosperity.

4. The Millennium Declaration and the MDGs provide a framework for addressing the high mortality rates in the Region. The pertinent goals call for reduction in hunger (MDG 1), reduction in under-five mortality rates (MDG 4) and improvement in maternal health (MDG 5) and combating HIV/AIDS, malaria and other diseases (MDG 6).

5. A number of affordable recommended interventions have been identified which could prevent 63% of current mortality if implemented at very high levels of coverage.[2] New and increased commitments are necessary to prioritize and accelerate child survival efforts and allocate resources within countries.

6. Partnerships, resources and more effective programmes at all levels are increasingly needed to reach the MDGs. Only a focused, coordinated effort and appropriate action by the international community and Member States can bring newborns and children the health care they need in a more efficient way.

7. In Africa, the Organisation of African Unity African Charter on the Rights and Welfare of the Child (1990), the adoption of the Integrated Management of Childhood Illness strategy by the WHO Regional Committee for Africa (1999) and the African Union Declaration on Child Survival (2005) recognize the duty to accelerate action for child survival.

8. The African Union requested all Member States to mainstream child survival into their national health policies. Health and child survival have been prioritized by the New Partnership for Africa's Development. The Delhi Declaration (2005) on maternal, newborn and child health and the

[1] WHO, *The world health report, 2005: Make every mother and child count*, Geneva, World Health Organization, 2005.
[2] Jones G et al, How many child deaths can we prevent this year? *Lancet* 362: 65–71, 2003.

subsequent Fifty-eighth World Health Assembly resolution[3] call for the highest political commitment.

9. This document provides strategic direction for Member States of the African Region to address child survival and development, decrease the unacceptably high child mortality rates and attain Millennium Development Goal 4.

SITUATION ANALYSIS AND JUSTIFICATION

10. The average decline in under-five mortality experienced globally over the years can be mainly attributed to the decline in rates in countries with rapid economic development.[4]

11. The situation of most African children remains critical and is exasperated by the serious poverty on the continent. A number of factors contribute to the slow reduction in the average annual mortality rate and the large disparities in child survival between and within developing countries. These include socioeconomic, cultural, traditional and developmental circumstances as well as natural disasters, armed conflict, exploitation and hunger. Poverty is the single most important factor accounting for low coverage of effective interventions.

12. In the African Region, infections are the main direct cause of child mortality. Although the relative importance of infections varies from country to country, on average, more than 70% of child deaths are attributed to just a few mainly preventable causes, namely, acute respiratory infections, diarrhoea, malaria, measles, malnutrition and neonatal conditions (asphyxia, prematurity, low birth weight and infections), singly or in combination. HIV/AIDS may account for up to 57% of under-five deaths in countries with the highest HIV prevalence.

13. The HIV pandemic has contributed to increased poverty, the erosion of the family and community support needed for child survival, and the human resource crisis in the health and other sectors. Although it is known that HIV treatment for children can reduce mortality and improve quality of life, very few countries have comprehensive approaches to paediatric HIV care and support.

14. Indirect determinants of health may vary between countries; however, malnutrition is a critical risk factor in most countries, and food and nutrition security remain fundamental challenges to child survival.[5] Lack of water and sanitation, poor living conditions, and inadequate child spacing are associated with high mortality. In Africa, water, sanitation and hygiene are seldom linked to national child survival strategies.

15. There are a few cost-effective interventions that could significantly reduce mortality, and these interventions vary greatly between and within countries. In some countries, progress achieved in the early 1980s and 1990s has not been sustained, and coverage rates have actually regressed. For

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[3] Resolution WHA58.31, Working towards universal coverage of maternal, newborn and child health interventions. In: *Fifty-eighth World Health Assembly, Geneva, 16–25 May 2005. Volume 1: Resolutions and decisions, and list of participants.* Geneva, World Health Organization, 2005 (WHA59/2005/REC/1), pp. 118–121.

[4] Ahmad OB, Lopez AD, Inoue M, The decline in child mortality: a re-appraisal, *Bulletin of the World Health Organization* 78(10): 1175-1191, 2000.

[5] Resolution WHA58.32, Infant and young child nutrition. In: *Fifty-eighth World Health Assembly, Geneva, 16–25 May 2005. Volume 1: Resolutions and decisions, and list of participants.* Geneva, World Health Organization, 2005 (WHA59/2005/REC/1), pp. 121–124.

example, use of insecticide-treated nets can reduce child deaths from malaria by about 17%,[6] but coverage remains low at about 15%[7] in Africa. Interventions such as oral rehydration therapy and treatment of acute respiratory infections seem to have lost their momentum. Newer interventions such as those for improving newborn health have received little attention because of misconceptions about their complexity and cost.[8]

16. There are multiple constraints in health systems that hamper effective scaling up of interventions. Insufficient human, financial and material resources coupled with limited managerial capability, out-of-pocket payments and inadequate mechanisms for families to access health care are just some of the factors that lead to poor service delivery and low coverage of interventions. Insufficient availability of essential drugs and supplies, and inadequate supervision of health-care providers are among the persistent problems of the health systems in many countries.

17. Financial resources for child survival programmes are far from adequate for reaching every community in every district with low-cost interventions. Globally, US$ 52.4 billion are needed to reach universal coverage in addition to current expenditures. This corresponds to US$ 0.47 per individual initially, increasing to US$ 1.48 in year 10 when 95% of the child population would be covered.[9]

18. In 1999, the WHO Regional Committee for Africa adopted Integrated Management of Childhood Illness (IMCI) as the major strategy for child survival and the reduction of the high child mortality rate in the Region.[10] IMCI has been found to be an effective delivery strategy for various child survival interventions and has contributed to a 13% mortality reduction over a two-year period in districts in Tanzania where it has been implemented.[11]

19. For greater impact, however, it is imperative to implement the IMCI strategy by applying the life-course approach and to coordinate its implementation with strategies for other relevant intervention areas. Growth and development during pregnancy is essential to ensure a healthy neonatal period. Reducing newborn morbidity, on the other hand, is essential to healthy growth and development during childhood, adolescence and adulthood. This requires a holistic approach which combines a comprehensive child survival strategy with strategies for eradicating extreme poverty and hunger, improving maternal health, and combating HIV/AIDS, malaria and other diseases.

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[6] Schellenberg JRA et al, Effect of large-scale social marketing of insecticide-treated nets on child survival in rural Tanzania, *Lancet* 357: 1241–1247, 2001.

[7] WHO/UNICEF, *World malaria report 2005*, Geneva, World Health Organization, 2005.

[8] Schellenberg JRA et al, Effect of large-scale social marketing of insecticide-treated nets on child survival in rural Tanzania, *Lancet* 357: 1241–1247, 2001.

[9] WHO, *The world health report 2005: Make every mother and child count*, Geneva, World Health Organization, 2005.

[10] Resolution AFR/RC49/R4, Integrated Management of Childhood Illness (IMCI): Strategic plan for 2000–2005. In: *Forty-ninth Session of the WHO Regional Committee for Africa, Windhoek, Namibia 30 August–3 September 1999, Final Report*. Harare, World Health Organization, Regional Office for Africa, 1999 (AFR/RC49/18), pp. 9–10.

[11] Armstrong Schellenberg, J et al, The effect of Integrated Management of Childhood Illness on observed quality of care of under-fives in rural Tanzania, *Health Policy and Planning* 19(1): 1–10, 2004.

THE REGIONAL STRATEGY

Objective

20. The objective of the strategy is to accelerate the reduction of neonatal and child mortality in line with the Millennium Development Goals by achieving high coverage of a defined set of effective interventions.

Guiding principles

21. The strategy is founded on the following principles:

(a) *Life-course approach:* This strategy promotes optimal growth and development of the fetus and across the 0 to 5 age group to prepare each individual for a healthy, well-adjusted, productive adult life, through coordinated implementation with other strategies aimed at achieving the MDGs and promoting health.

(b) *Equity:* Emphasis will be on ensuring equal access to child survival interventions for all children.

(c) *Child rights:* Rights-based planning will be incorporated in child health interventions to ensure protection of the most vulnerable.

(d) *Integration:* All efforts will be made to implement the proposed priority interventions at various levels of the health system in a coherent and effective manner that is responsive to the needs of the child.

(e) *Multisectoral collaboration:* Considering that health issues are development issues, achieving health outcomes requires contributions from other sectors.

(f) *Partnerships:* Emphasis will be put on developing new partnerships and strengthening existing ones to ensure that child survival interventions are fully integrated in national and district health systems in a sustainable way.

Strategic approaches

22. The strategic approaches are:

(a) *Advocating for harmonization of child survival goals and agendas* in order to promote, implement, scale up and allocate resources to achieve the internationally-agreed goals and targets;

(b) *Strengthening health systems* by building capacity at all levels of the health sector and ensuring quality service delivery to achieve high population coverage of child survival interventions in an integrated manner;

(c) *Empowering families and communities,* especially the poor and marginalized, to improve key child-care practices and to make the treatment of malaria, pneumonia, diarrhoea and HIV/AIDS available within the community;

(d) *Forming operational partnerships* to implement promising interventions with government in the lead, and donors, NGOs, the private sector and other stakeholders engaged in joint programming and co-funding of activities and technical reviews;

(e) *Mobilizing resources* at international, regional and government levels for child survival to scale up proven interventions.

Essential package of services

23. **Integrated Management of Childhood Illness** will remain an important *delivery mechanism* for most of the priority interventions listed below. In addition, strong linkages with Road Map for accelerating the attainment of MDG 5 and Making Pregnancy Safer (MPS) services will be promoted, especially for newborn care and Prevention of Mother-to-Child Transmission of HIV (PMTCT).

24. **Newborn care.** Taking into consideration the life-course approach and continuum of care, neonatal interventions that need to be scaled up will include access to skilled care during pregnancy, childbirth and the immediate postnatal period at community and facility level. Capacity building of professional and non-professional staff will include optimal newborn care practices of newborn resuscitation, early and exclusive breastfeeding, warmth, hygienic cord and skin care as well as timely and appropriate care-seeking for infections and care of low-birth-weight infants. The Making Pregnancy Safer initiative through Integrated Management of Pregnancy and Childbirth offers opportunities for addressing early newborn health. Integrated Management of Childhood Illness will also be expanded to include newborns in the first seven days of life.

25. **Infant and Young Child Feeding, including micronutrient supplementation and deworming.** Key interventions to be emphasized are exclusive breastfeeding for the first six months of life, including colostrum, timely and appropriate complementary feeding, and adequate micronutrient intake (particularly vitamin A, iron and iodine). Regular deworming throughout childhood and during pregnancy will be promoted for its functional and developmental benefit. Special emphasis will be given to prevention and treatment of malnutrition. Integration of Infant and Young Child Feeding in other child health services, such as Baby Friendly Hospital Initiative, IMCI, PMTCT, and Growth Monitoring Promotion and Referral, provides critical entry for scaling up these interventions.

26. **Prevention of malaria using insecticide-treated nets and intermittent preventive treatment of malaria.** Use of insecticide-treated nets (ITNs) for both under-fives and pregnant mothers and incorporating intermittent preventive treatment of malaria (IPT) during pregnancy in malaria-endemic areas are priority interventions for reducing low birth weight, child morbidity and child mortality. One mechanism to ensure universal access to ITNs is to provide free or subsidized ITNs on a regular basis or through campaigns. ITNs and IPT should be integrated with the Expanded Programme on Immunization (EPI), antenatal care and IMCI activities to increase coverage rapidly.

27. **Immunization of mothers and children.** Provision of tetanus toxoid to pregnant women in antenatal clinics and childhood immunizations, including new vaccines, at community and facility levels through outreach and fixed services will be promoted. Proven ways of improving access to and coverage of services include outreach campaigns to provide services to the remote and integration of EPI with other child survival interventions such as vitamin A, deworming and ITN distribution. The implementation of this child survival strategy will be closely coordinated with the implementation of the WHO/UNICEF Global Immunization Vision and Strategy.

28. **Prevention of Mother-to-Child Transmission of HIV.** The key to ensuring an HIV-free start in life is the prevention of HIV transmission to children by preventing HIV infection in mothers. Other interventions are family planning, antiretroviral therapy, counselling in infant feeding and support for HIV-infected women and their infants in countries with high HIV prevalence. Integration

of PMTCT interventions in antenatal care, nutrition programmes, IMCI and other HIV/AIDS services enhances opportunities for reducing paediatric HIV and the associated deaths.

29. **Management of common childhood illnesses and care of children exposed to or infected with HIV.** Interventions include oral rehydration therapy and zinc supplementation for the management of diarrhoea; effective and appropriate antibiotic treatment for pneumonia, dysentery and neonatal infections; and prompt and effective treatment of malaria at health facility and community levels. Care of HIV-exposed and HIV-infected children is the key to improved quality of life. Integrated Management of Childhood Illness provides an approach for addressing these common illnesses in an integrated manner.

Implementation Framework

30. To achieve universal coverage with these interventions, this strategy proposes that countries base their health system and long-term plans on a suitable mix of delivery channels based on the following service delivery modes:

(a) ***Family-oriented, community-based services*** that can be delivered on a daily basis by trained community health or nutrition promoters with periodic supervision from more skilled health staff;

(b) ***Population-oriented scheduled services*** that require health staff with basic skills (e.g. auxiliary nurses, midwives and other para-medical staff) and can be delivered either by outreach or in health facilities in a scheduled way;

(c) ***Individually-oriented clinical services*** that require health workers with advanced skills (such as registered nurses, midwives or physicians) available on a permanent basis.

31. Not all countries can currently ensure full coverage of the whole range of interventions. Obstacles to comprehensive implementation of the continuum-of-care concept across service delivery modes will need to be addressed in the medium and long term. To facilitate long-term planning, the strategy identifies a phased approach that allows each country to define and implement an essential package of service interventions that, over time and with increasing coverage, can then be expanded to arrive at an optimal (or maximum) package of interventions. The essential packages include:

(a) A ***minimum package*** of high-impact, low-cost interventions that need to be implemented at scale immediately. The minimum package may include ITNs for pregnant women and infants; antenatal care ; promotion of early, exclusive and prolonged breastfeeding; neonatal care; routine immunization of mothers and children; vitamin A supplementation; deworming; complementary infant feeding; oral rehydration therapy and zinc supplementation for diarrhoea; malaria treatment, including artemisinin-based combined therapy; management of pneumonia in newborns and children; antiretroviral drugs for the management of paediatric AIDS; and birth spacing;

(b) An ***expanded package*** equivalent to the minimum package plus additional evidence-based interventions such as expanded neonatal care, *Haemophilus influenzae* type B vaccine, and emergency obstetric care;

(c) A ***maximum package*** equivalent to the expanded package plus new planned interventions such as rotavirus and pneumococcal vaccine, and intermittent preventive treatment of malaria in young children.

32. The total resources required to implement the strategy for each of the proposed packages through the various delivery modes is indicated in a separate document to be finalized.

ROLES AND RESPONSIBILITIES

Countries

33. Governments will take the lead in ensuring an integrated and focused approach to programme planning and service delivery to scale up newborn and child health interventions. They will ensure certain priority interventions for universal access and high coverage among under-five children, including newborns. Specific roles of countries will be:

(a) *Policy development*: To put in place the necessary policies that allow effective scaling up of interventions;

(b) *Capacity building*: To strengthen national capacity to effectively plan, implement and monitor activities, including implementation of policies that address child survival and related health system constraints;

(c) *Communication and social mobilization*: To ensure relevance and consistency of messages for priority child survival interventions, countries will develop a national communication strategy to support integrated health promotion activities with a focus on empowering families, households and communities, ensuring clear links with effective delivery of essential services by different sectors, institutions and players;

(d) *Advocacy and partnership development:* To advocate and develop partnerships within the framework of the Maternal, Newborn and Child Health Partnership by ensuring consensus building, harmonization of interventions and resource mobilization from within and outside the country; this includes child survival interventions in the various global and national development initiatives such as Poverty Reduction Strategy Papers, sector-wide approaches and the Global Fund to Fight AIDS, Tuberculosis and Malaria as well as close collaboration with partners in the health sector and linkages with other programmes such as malaria control, HIV/AIDS, Maternal and Neonatal Health, EPI, Integrated Disease Surveillance and Response, and Health System Development;

(e) *Operational research:* To conduct operational research in priority areas in order to improve policy, planning, implementation and scaling-up of cost-effective child survival interventions;

(f) *Documentation:* To assess, document and share their experiences and programme efforts to achieve set goals and apply the lessons during the expansion phase and for advocacy purposes;

(g) *Development of a framework for monitoring and evaluation:* To develop a framework for monitoring and evaluation that includes gathering baseline data, tracking progress, documenting and sharing experiences with countries and regions.

WHO, UNICEF, World Bank and other partners

34. WHO, UNICEF, World Bank and other partners will:

(a) advocate for the priority interventions and mobilization of resources;

(b) provide technical support to countries to scale up child survival interventions by strengthening country and intercountry capacity, monitoring and evaluation mechanisms, and health management information;

(c) support countries to identify, document and disseminate best practices in implementing these interventions;

(d) support countries to develop capacity for operational research;

(e) facilitate coordination and collaboration.

MONITORING AND EVALUATION

35. A minimum set of process and impact indicators to track progress will be agreed upon with partners and stakeholders.

36. The monitoring process will conform to child rights principles. Information and results will be stratified by various groups so that comparisons can be made about the impact of different policy and programme measures. Evaluation will be conducted every two years.

CONCLUSION

37. Children represent the future of Africa. Hence, investing in children's health is imperative in ensuring healthier and more productive future generations who will guide the socioeconomic development of the continent.

38. This strategy reflects a life-course and comprehensive approach to child health issues and health-care service delivery. It underscores the need for implementing cost-effective maternal newborn and child health interventions for reducing newborn deaths by three fourths and child deaths by two thirds in the largest population possible.

39. The key to making progress towards attaining Millennium Development Goal 4 by 2015 is reaching every newborn and child in every district with a few priority interventions. The interventions described above are not new; however, this strategy calls for a strong commitment to prioritize interventions, allocate resources and accelerate a few known cost-effective child survival interventions for implementation at high levels of population coverage.

40. The Regional Committee is requested to review the Regional Child Survival Strategy proposed by WHO, UNICEF and the World Bank, and adopt it and the attached resolution for use by countries.