IMPROVING CHILD SURVIVAL: MATERNAL AND CHILD HEALTH INCLUDING IMMUNIZATION

In the Western Pacific Region, approximately 2100 children under five years of age die every day from common conditions occurring in the newborn period, pneumonia, diarrhoea, measles and undernutrition. However, wide disparities in child mortality exist from country to country among different geographical areas and population groups within countries.

The WHO/UNICEF Regional Child Survival Strategy was developed as a collaborative effort of related programmes and partner agencies. It was endorsed in resolution WPR/RC56.R5 by the WHO Regional Committee for the Western Pacific at its fifty-sixth session. The Committee, in resolution WPR/RC56.R8, also decided that the Region should aim by 2012: (1) to eliminate measles; and (2) to reduce the seroprevalence of HbsAg to less than 2% in 5-year old children. The Strategy outlines an essential package of child survival interventions, including skilled attendance during pregnancy, delivery and the immediate postpartum period, newborn care, nutrition, immunization of children and mothers, integrated management of childhood illness and other measures. The Strategy was launched in May 2006 in six countries with the highest burden of child mortality.

Many countries in the Region have made progress towards achieving Millennium Development Goals 4 and 5. However, gains have been uneven within and across countries.

The Regional Committee is urged to reaffirm the commitment of Member States to implement their national maternal and child survival plans in order to achieve agreed upon regional goals and ensure universal access to the essential package for child survival.
1. CURRENT SITUATION

Millennium Development Goals (MDGs) 4 and 5 aim to reduce under-5 child mortality by two thirds and maternal mortality ratio by three quarters, respectively, by 2015 compared with levels observed in 1990. Improvements in maternal and child survival have been achieved in the Western Pacific Region since these goals were set in 2000. An estimated 766 000 children die annually in the Region before reaching their fifth birthday, accounting for almost 2100 under-5 deaths every day.° More than 95% of these deaths occur in six countries in the Region. ² In many of these countries, neonatal mortality accounts for almost half of all under-5 deaths, followed by pneumonia, diarrhoea and measles in the post-neonatal period. High undernutrition levels further compound the problem. Considering the high contribution of neonatal mortality to overall under-5 mortality, achievement of MDG 4 is intricately linked with achievement of MDG 5.

The WHO/UNICEF Regional Child Survival Strategy, endorsed in resolution WPR/RC56.R5 by the WHO Regional Committee at its fifty sixth session in 2005, identified an essential package of core interventions to be implemented universally. The essential package for child survival includes skilled attendance during pregnancy, delivery and the immediate postpartum period, newborn care, nutritional interventions, immunization of children and mothers, the integrated management of childhood illness, and the use of insecticide-treated bednets in malarious areas. In the same session, the Committee also decided that the Region should aim by 2012: (1) to eliminate measles; and (2) to reduce the seroprevalence of HbsAg to less than 2% in 5-year old children which will require 95% two-dose coverage with measles vaccine and a birth dose of hepatitis B vaccine. Increased access to and utilization of these essential health services at birth, throughout infancy and during childhood, will create opportunities to provide other essential health interventions that will further reduce maternal, neonatal and child mortality.

In 2006, the Strategy was launched in the six countries with the highest burden of childhood deaths. ³ Countries have responded by reviewing past approaches and developing national strategic and operational plans for maternal and child survival including immunization. For example, Cambodia developed a national child survival strategy and drafted and costed an integrated national plan for scaling up key child survival interventions. China extensively reviewed its maternal and child survival strategies and utilized the results to guide policy formulation and strategic directions. The

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² Cambodia, China, the Lao People's Democratic Republic, Papua New Guinea, the Philippines and Viet Nam.
Philippines completed a child survival situation analysis and is drafting a package of services customized to the needs of children in specific geographic areas.

The Integrated Management of Pregnancy and Childbirth was introduced in seven priority countries. All these countries have developed guidelines and service protocols based on the manual *Managing Complications in Pregnancy and Childbirth*. Viet Nam has analysed issues for further action in newborn care. However, neonatal mortality in these countries remains unacceptably high.

To reduce childhood morbidity and mortality in primary health care settings, the Integrated Management of Childhood Illness (IMCI) was introduced as the key approach in the late 1990s. Mongolia has implemented IMCI nationwide and the Philippines has achieved coverage in more than 50% of its districts. Another 12 countries have a varied geographical coverage. To complement IMCI, the focus has been expanded to improve the quality of care for neonates and for children in hospital settings, which will provide a continuum of care across different levels of the health care system.

In a 2006 update of progress towards the MDGs, child survival was found to have improved markedly in Eastern Asia, where child mortality rates have declined by more than 3% annually. In terms of progress towards MDG 4, three groups of countries can be distinguished: (1) those countries currently close to the 2015 under-5 mortality goal (e.g. Viet Nam); (2) those where the goal could be achieved if recent declining trends continue (e.g. China, the Lao People's Democratic Republic and Papua New Guinea); and (3) those countries with progress but requiring substantial efforts to reach the goal (e.g. Cambodia). China, the Philippines and Viet Nam show a declining trend of under-5 mortality with the current rates below 35 deaths per 1000 live births. The Lao People's Democratic Republic and Papua New Guinea show decreasing trends in under-5 mortality but at rates still above 70 deaths per 1000 live births. In Cambodia, mortality trends also seem to point to a decline after a period of flattening, although overall mortality rates are still among the highest in the Region. Overall, the progress noted for child mortality reduction is greater than for infant mortality.

Coverage for key interventions that contribute to a reduction in under-5 mortality show varying degrees of improvement. Breastfeeding prevalence has not significantly improved since 1990 with approximately 45% of children exclusively breastfed to 6 months of age. The Western Pacific Region led all other WHO regions in reducing measles mortality, by reporting an 81% decline between 1999 and 2005 due to increased measles immunization coverage. Viet Nam achieved

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3 Ibid.
4 Cambodia, China, the Lao People's Democratic Republic, Mongolia, Papua New Guinea, the Philippines and Viet Nam.
6 Western Pacific Country Health Information Profiles 2006 Revision.
elimination of neonatal tetanus in 2005. Vitamin A supplementation has improved for most Member States. Data from Cambodia, the Lao People's Democratic Republic and the Philippines reveal that less than 50% of children under 5 with suspected pneumonia receive appropriate care. Provision of oral rehydration therapy for children with diarrhoea is better. In most countries, coverage equity for most interventions including antenatal care, tetanus toxoid, skilled attendant at birth, Bacille Calmette-Guérin (BCG), diphtheria, tetanus, pertussis (DTP) and measles vaccination, and vitamin A supplementation show a wide gap in service delivery and consequently coverage between the lowest- and the highest-wealth quintiles. Almost 30% of births in the Region take place without skilled care. In the seven countries and regions where maternal and newborn mortalities are high, coverage for access to skilled birth attendance, emergency obstetric care and newborn care needs to be improved.

Collaboration with partner agencies, including the Australian Agency for International Development, the United Nations Children’s Fund, the United States Agency for International Development, the European Commission Humanitarian Aid Department, and the United Nations Population Fund, was significantly strengthened over the past year. The joint WHO/UNICEF Regional Child Survival Strategy implementation in priority countries received significant support from Australia and Japan. The United Nations Children’s Fund and the United Nations Population Fund have provided support to countries and areas for training skilled attendants and providing a continuum of care for mothers and newborns. But support from various international agencies and local nongovernmental organizations has not been sufficient to address all the issues of maternal and child survival.

2. ISSUES

There are several factors that have presented challenges to the reduction of under-5 mortality and maternal mortality in many countries of the Region. After an impressive decline following the child survival revolution of the 1980s, there has unfortunately been a slower rate of decline in child mortality trends. The reduction of maternal mortality ratio has been painfully slow.

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2.1 Inadequate high-level support and commitment

Child health and survival seem to command a relatively high emotional appeal, but the commitment in terms of accelerated action to reduce the current high number of child deaths is still not optimal in many countries and settings. The commitment to maternal health and reducing maternal mortality, which is intricately linked to neonatal survival and health, remains low in some countries. Greater attention to underserved areas and population groups is required to reduce existing inequities.

2.2 Low coverage of and poor access to service

There are many reasons why women, neonates and children are not covered by essential services. Geographical access is a challenge in some countries, with mothers and children living in remote and difficult-to-reach rural areas. Even within easy-to-reach populations, there are disadvantaged groups of women and children who do not have access to child survival and maternal health services, such as migrant (especially if illegal) populations, and urban poor families. Community awareness and motivation also may affect coverage, as exemplified by low breastfeeding prevalence, low coverage for antenatal services and skilled attendance at birth. Removing financial barriers to access is a challenge in most countries.

2.3 Expanding the range of child survival interventions

The WHO/UNICEF Regional Child Survival Strategy: accelerated and sustained action towards MDG 4 identifies an essential package of child survival interventions and classifies countries of the Region into three categories. The Strategy is not a static set of recommendations, and countries can expand services as the situation warrants and allows. Newer technologies and interventions are continually being introduced. New or underused vaccines such as *Haemophilus influenzae* type B, pneumococcal conjugate and rotavirus vaccines that target common causes of pneumonia and diarrhoea in children under 5 have been introduced in parts of countries and areas as resources permit. Rapid uptake of these vaccines can help to reduce child mortality by about 15%–17%. The use of low osmolarity oral rehydration salts and zinc supplementation among children with diarrhoea has been proposed as a standard home care for diarrhoea.

2.4 Weaknesses in health service delivery systems

Human resources are an issue in many countries, which has led to the consideration of strategies such as multitasking and the use of volunteers. Delegation of specific tasks to trained
community health workers has proven to be a safe and effective strategy. In many countries, however, laws and regulations prevent the effective expansion of such service delivery networks. Nevertheless, human resources concerns do not only relate to numbers and distribution, but also to skills and updated knowledge of providers. A major area of concern is coverage by skilled birth attendants. Financial accessibility to services is another nagging issue. Many countries still have a fee-for-service model for some services and interventions, often making these services unaffordable to some mothers and children.

2.5 Lack of an integrated outcome-oriented monitoring and evaluation for maternal and child health including immunization

Regular monitoring, complemented by impact evaluations every four to five years, of health outcomes, health service outputs and programme inputs, by mechanisms to which all stakeholders agree, is crucial. Standardized indicators ensure comparability and help avoid duplication of effort. In addition, monitoring and evaluation systems should not only look at aggregate performance but also performance among identified disadvantaged groups.

3. ACTIONS PROPOSED

The following actions by Member States are proposed for consideration by the Regional Committee:

(1) **Reaffirm and strengthen national commitment to maternal and child survival.** Countries need to strengthen national commitments to ensure that maternal, newborn and child health, including support for achieving the twin regional goals of measles elimination and hepatitis B control by 2012, are included in national health and development plans. Many maternal and child health interventions remain dependent on external funding, with low levels of national investment. This has to change gradually to ensure long-term sustainability. Costing of national plans and financial analyses of funding gaps are important activities to accelerate efforts towards the achievement of the Millennium Development Goals.

(2) **Improve coverage of services to reach disadvantaged populations.** Inequities in child and maternal health status are not the result of the lack of effective interventions. Mounting evidence shows that the lack of investments, together with the lack of strategic delivery
channels, have resulted in disproportionately low coverage of mothers and children most in need. The efficient utilization of multiple delivery channels to implement integrated sets of interventions will ensure access to services and a more equitable coverage of essential interventions.

(3) **Assess the need for newer interventions.** Reducing under-5 mortality requires sustained and improved coverage with existing interventions and the introduction of new interventions. Vaccines targeting common causes of pneumonia and meningitis (*Haemophilus influenzae* type B and pneumococcal conjugate vaccines) and diarrhoea (rotavirus vaccine) have become available recently. The high cost of these vaccines has prevented nationwide implementation by countries and areas. However, an assessment of the cost effectiveness of such interventions may suggest that more widespread introduction of these vaccines is desirable. Countries are encouraged to manufacture and use the low osmolarity oral rehydration salts and provide zinc supplementation for children with diarrhoea.

(4) **Strengthen the health care system.** Efforts to strengthen capacity-building and the supervision of health care providers, coupled with adequate and sustainable logistic support for essential supplies and equipment, are important. Enhanced family and community support and an improved referral care system will increase intervention quality across the continuum of care.

(5) **Adopt an integrated outcome-oriented monitoring and evaluation for maternal and child health, including immunization.** Support is needed for countries and areas to review monitoring and evaluation systems that are currently oriented to collect data on vertical programmes. If possible, an integrated system that is useful for decision-making, with reconciliation of statistics from different data sources, should be developed to measure health status, intervention coverage, and the outputs and inputs of maternal and child health services and programmes. Data should be disaggregated according to socioeconomic quintiles, age, gender, ethnicity and geographical area to enable their use in formulating strategies to reduce inequity.