WHO/UNICEF
Regional Child Survival Strategy
Accelerated and Sustained Action Towards MDG 4


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List of abbreviations

AIDS  Acquired Immunodeficiency Syndrome
BCG  Bacille, Calmette - Guerin
BFHI  Baby Friendly Hospital Initiative
DHS  Demographic and Health Survey
EPI  Expanded Programme on Immunization
HIV  Human Immunodeficiency Virus
IECD  Integrated Early Childhood Development
IMCI  Integrated Management of Childhood Illness
IMPAC  Integrated Management of Pregnancy and Childbirth
IYCF  Infant and Young Child Feeding
MDG  Millennium Development Goal
MICS  Multi-indicator Cluster Survey
MPS  Making Pregnancy Safer
NGO  Nongovernmental Organization
ORS  Oral Rehydration Salts
ORT  Oral Rehydration Therapy
PMTCT  Prevention of Mother-to-Child Transmission of HIV
UNICEF  United Nations Children’s Fund
WHO  World Health Organization
Foreword

In the past few years, the countries and areas of the Western Pacific Region of the World Health Organization and the East Asia and Pacific Region of the United Nations Children’s Fund have experienced numerous communicable disease outbreaks. These public health emergencies have received worldwide attention, putting these outbreaks at the centre of debate among scientists and health professionals as well as decision-makers in the political and economic arenas. News about these epidemics pours into homes through local and international media.

At the same time, 3000 children under 5 years of age are dying daily from a handful of preventable and treatable conditions in a silent epidemic that stretches across the Region. While the death of a child is a catastrophe without comparison for a family, it appears as only a figure in mortality statistics — and often not even a figure as hundreds of lives are lost without being ever recorded. Children have no voice, and their needs are overshadowed by other priorities. The tragedy of our times is that almost all of these childhood deaths could be avoided with well-known, tested and cost-effective interventions. Yet, they don’t reach those in need.

We, therefore, need to transform our policy parameters. It is our moral imperative to change the course of action in the Region and translate the promises that have been made at numerous international conferences into action. Children represent the Region’s future. Improving child health will benefit the economic and social development of Member States, provide a major contribution to sustainable poverty reduction, and guarantee that the rights of children are fulfilled. But improved child survival will not be possible without the determination to give children a voice and a commitment to place child health high on the political, economic and development agendas. Increased financial commitments by both national governments and donors also are needed.
The purpose of this joint WHO/UNICEF Regional Child Survival Strategy is to mobilize the resources of the two organizations most involved in child health to stimulate an accelerated drive to save children’s lives, making concrete the commitment of all Member States to the development goals of the United Nations Millennium Declaration, most specifically Millennium Development Goal 4: reduce child mortality. The Strategy offers a unified direction and a description of the actions necessary to successfully implement life-saving interventions. As such, it can be used to guide countries in the Region in their efforts to improve child survival. It can also serve as an advocacy document for focused and convergent programmes and donor coordination. Progress in child health can only be realized if inequities in the health and well being of children in the Region are addressed. This strategy focuses on children from birth to 5 years of age and advocates approaches that give every child the same chance for survival.

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1 Background

In the Region, it has been estimated that 3000 children under 5 years of age die every day from common preventable and treatable conditions including diarrhoea, pneumonia, and perinatal events. Many of these deaths are associated with undernutrition. Vaccine preventable diseases and injuries further contribute to this high number of childhood deaths.

Most childhood deaths occur in low-income countries or poor communities in middle-income countries where many deaths are unrecorded. Six countries (Cambodia, China, the Lao People’s Democratic Republic, Papua New Guinea, the Philippines and Viet Nam) account for more than 75% of all deaths among children under 5. As many as 800 000 children under 5 will continue to die every year in these countries if current trends continue.

Countries of the Region are committed to the development goals of the United Nations Millennium Declaration (MDG). MDG 4 calls for a reduction by two thirds, between 1990 and 2015, of the under-5 mortality rate. This goal is contingent on progress with other MDGs, particularly MDG 1 (eradicate extreme poverty and hunger) and MDG 5 (improve maternal health). Few countries in the Region are on track to achieve these goals, and significant action must be taken to improve child survival and achieve MDG 4.

The Convention on the Rights of the Child, acknowledged by all countries of the Region, and the convention’s monitoring body, the United Nations Committee on the Rights of the Child, provide a valuable framework for child health.

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1 Region is defined as countries and areas common to the WHO Western Pacific Region and the UNICEF East Asia and Pacific Region. In addition, some Pacific island nations not covered by any UNICEF programme are included.
Article 6 of the Convention specifically affirms the inherent right to life of every child, and Article 24 addresses the right to health and health care.

The World Health Organization (WHO) Regional Committee for the Western Pacific at its fifty-fourth session adopted resolution WPR/RC54.R9 that strongly urged Member States to place child health higher on their political, economic and health agendas and to allocate and utilize financial resources from all available sources to match the burden of childhood disease (Annex 1). This prompted a new drive to reduce child mortality in Member States, particularly in areas of greatest need.

The renewed commitment and emphasis on childhood mortality reduction warrants a regional strategy for child survival that accommodates the most important life-saving interventions and leads to a childhood mortality reduction in the Region in line with the MDG. Action is required through resource mobilization, stronger outcome orientation, advocacy and monitoring that addresses the existing limitations in human and financial resources that currently prevent optimizing the delivery of life-saving interventions to improve child survival. WHO and the United Nations Children’s Fund (UNICEF) have joined forces to develop this strategy. The document is intended for governments of Member States, policy-makers and partner agencies.

This joint WHO/UNICEF Regional Child Survival Strategy was endorsed by the fifty-sixth session of the WHO Regional Committee for the Western Pacific (Annex 2).
2 Rationale for accelerated and sustained action for child survival

2.1 STAGNATING MORTALITY REDUCTION

The child survival revolution of the 1980s greatly reduced child mortality, particularly in the 1-4 year age group. Since then, however, there has been slow reduction in child mortality and increasing evidence of disparities. The infant and under-5 mortality rates in the Region show a deceleration in improvement, with an actual worsening in some countries (Figure 1). A worsening in the under-5 mortality rate has occurred in Cambodia since 1994. Kiribati, Papua New Guinea and the Philippines have shown little change in the last 10 years.

Cost-effective, evidence-based strategies to deliver child survival interventions have been implemented only to a limited degree. They have not received due attention or the investment necessary to take them to scale.

Figure 1: Under-five mortality rate in selected countries in the Region, 1990-2003 or latest year available
2.2 PERSISTENCE OF THE MAJOR CAUSES OF CHILDHOOD MORTALITY

Recent child and neonatal health data from the Region on causes of death in 0-4 year old children show a yearly average of approximately 1.02 million deaths over 2000-2003. Main causes of mortality in high-mortality areas are shown in Figure 2.

Neonatal events are estimated to account for 32% of the deaths, and the proportion tends to increase in areas where the total under-5 mortality decreases. There is evidence at the global level that most neonatal deaths are caused by infections (36%), birth asphyxia (23%), complications due to premature birth (28%) and congenital anomalies (8%).

Acute lower respiratory infections are still the single most important cause of death (20%) among children under 5 years old, with diarrhoea a close second cause (18%). Measles remains a cause of 2.4% of childhood deaths. While malaria does not account for a high total percentage of child deaths in the Region, it is a cause of high child mortality in some countries such as the Lao People’s Democratic Republic, Papua New Guinea and high-mortality provinces in Cambodia. HIV/AIDS is an emerging problem in the Region and is related to about 1% of mortality among children under 5, primarily in relation to mother-to-child transmission.

Undernutrition is an underlying cause in around 50% of deaths. Globally it contributes to 61% of deaths from diarrhoea, 57% from malaria, 52% from pneumonia and 45% from measles. Latest demographic and health surveys (DHS) and national statistics from countries and areas in the Region show that only 5%-23% of infants aged 4-6 months are reported to be exclusively breastfed in Cambodia,
the Lao People’s Democratic Republic and Viet Nam. Complementary foods are often introduced too early and lack nutrient density and adequate levels of micronutrients.

Maternal health and nutrition status before and around conception, as well as during pregnancy, significantly influence foetal development and the potential for survival after birth. Of the 30,000 maternal deaths every year in the Region, more than 40% occur in Cambodia, the Lao People’s Democratic Republic, Papua New Guinea, the Philippines and Viet Nam. The total fertility rate is still very high in some countries and areas.

Access to health services is unequal across and within countries and areas due to geographic, financial and other barriers. Health service utilization in some areas is very low partly because of poor quality of care, particularly in disadvantaged areas.

About 20% of the population of the Region still lacks access to safe water for drinking and food preparation, and nearly 1 billion people lack access to adequate sanitation. These factors underlie almost 90% of the deaths from diarrhoea. Countries with the lowest level of access are precisely those that have the highest rates of under-5 mortality. Large disparities also persist within countries. These disparities and their consequences are most severe in urban slums and rural communities.

Unsafe environments that contribute to unintentional injuries, drowning, poor environmental hygiene, and indoor air pollution prevail in many parts of the Region. In countries and areas in transition, the proportion of childhood deaths due to accidents and injuries is increasing. In the WHO Western Pacific Region, for example, it is estimated that 7% of childhood deaths are caused by injury.

### 2.3 CONTINUED DISPARITIES

While many countries and areas in the Region are known for economic prosperity, there are enormous disparities between countries and areas reflected in the wide range of national rates of infant and under-5 mortality and undernutrition. Furthermore, analysis of some indicators suggests that the disparities are widening.4

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There are also large disparities within individual countries as shown in Figure 3, illustrating the variations in under-5 mortality in some countries of the Region. Cambodia shows the greatest variance: Phnom Penh has an under-5 mortality rate of 50, while two provinces in the north-east have the rate greater than 220.

The disparities are not only geographical but are also found across socio-economic strata. For example, in Viet Nam the poorest quintile is reported to experience more than three times higher under-5 mortality rates than the richest quintile (Figure 4).
2.4 INSUFFICIENT FUNDING FOR CHILD SURVIVAL

An estimated $34 per capita is required for basic health services including an essential package for child survival.\(^5\)

Many countries and areas do not allocate enough general government resources to health; the allocation for tax revenue to health is insufficient and mechanisms such as insurance for collecting more resources are not well developed. Most of the under-5 high-mortality countries and areas spend less than 5% of their gross domestic product on health, and the per capita health spending is lower than recommended by the Commission on Macroeconomics and Health (Figure 5). Additionally, processes such as decentralization of health care financing may affect public health interventions if not linked with capacity-building. Due to the relatively modest government contribution to overall health care financing and the limited financial protection mechanisms for the poor, households continue to face financial barriers to needed health care. The broad use of out-of-pocket payments increases inequity in accessing and financing of health care. Sometimes, a health expenditure can be catastrophic for a household, and many low-income families are pushed deeper into poverty.

Many countries and areas in the Region are unable to generate sufficient resources to independently finance their health systems. Regional donors pledged to spend 0.7% of their gross national income on official development assistance. However, it is clear that greater efforts are needed in order to realize this commitment. Donor funding for child survival is very low compared with the high number of child deaths, commitment to the MDG, a moral obligation to protect vulnerable children, and the fact that extremely cost-effective interventions exist.

2.5 LACK OF COHERENCE AND VISIBILITY

Several evidence-based strategies have been promoted to reduce child mortality. While notable successes have been achieved on some fronts, for example the reduction in measles mortality, and in selective intervention areas, progress towards national coverage of a full package of life-saving interventions has been slow. This is largely due to a lack of focus on the major causes of mortality, the failure to invest sufficiently in proven interventions, and the lack of human resources needed to implement them. The low visibility of child health globally in the 1990s as other health problems have gained increased attention, and inadequate coordination among organizations have also contributed to the slow progress.
3.1 GOAL

To reduce inequities in child survival and achieve national targets for MDG 4 by accelerating and sustaining actions to reduce childhood mortality.

3.2 OBJECTIVES

• To improve access to and utilization of the essential package for child survival particularly in areas of greatest need; and
• To provide an enabling environment for child survival where political will, financial and human resources match the burden of disease.

3.3 STRATEGIC APPROACHES

• Improve leadership and governance;
• Consolidate partnerships;
• Improve efficiency and quality of service delivery;
• Engage and empower families and communities; and
• Ensure health care financing support for child survival.
4 Essential package for child survival

A series in The Lancet in 2003 extensively reviewed key child survival interventions. These articles estimated that two thirds of child deaths could be prevented by universal coverage of 23 interventions by virtue of the strength of the evidence for the effect of each on child mortality.⁶ Also, 16 interventions with proven efficacy for neonatal survival were reviewed and presented in another series in 2005 in The Lancet.⁷ In areas with high child mortality, high coverage with a selected subset of these interventions delivered through an essential package could substantially reduce neonatal and child mortality.

The WHO/UNICEF Regional Child Survival Strategy focuses on the implementation of an Essential package for child survival. This package is composed of the following:

- Skilled attendance during pregnancy, delivery and the immediate postpartum
- Care of the newborn
- Breastfeeding and complementary feeding
- Micronutrient supplementation
- Immunization of children and mothers
- Integrated management of sick children
- Use of insecticide-treated bednets (in malarious areas)

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4.1 SKILLED ATTENDANCE DURING PREGNANCY, DELIVERY AND THE IMMEDIATE POSTPARTUM

Important child survival interventions provided through skilled attendance during pregnancy include: antenatal care with a haemoglobin estimate for maternal anaemia, urine protein and blood pressure monitoring for prevention and management of pre-eclampsia and eclampsia, prevention and treatment of malaria, counselling for breastfeeding, preparation of a birth plan, detection of complications, and early referral of complications. At delivery and in the immediate postpartum period it is necessary to have a skilled attendant who can ensure a clean delivery, use a partogram and delivery kit, recognize complications, and refer, if necessary.

4.2 CARE OF THE NEWBORN

Low-cost, evidence-based interventions that should be available as part of national newborn care guidelines include clean cord care, newborn resuscitation, newborn temperature management, initiation of breastfeeding within one hour of delivery, weighing the baby to assess for low birth-weight, kangaroo mother care for low birth-weight babies, and case management of neonatal pneumonia and sepsis. Postnatal care also needs to be ensured.

4.3 BREASTFEEDING AND COMPLEMENTARY FEEDING

Improved infant and young child feeding practices need to be protected, promoted and supported with exclusive breastfeeding up to 6 months of age, continued breastfeeding up to 2 years of age or beyond, and adequate and safe complementary feeding from 6 months onwards.
4.4 MICRONUTRIENT SUPPLEMENTATION

For the reduction of child mortality, the most important micronutrient supplementation is Vitamin A, given every six months for children aged 6-59 months. Micronutrient supplementation of the mother, including iron and folic acid provided through antenatal care and Vitamin A given in the postnatal period may be determined by national guidelines. Improved diets including fortification and supplementation of food are necessary to achieve appropriate micronutrient levels for children and mothers.

4.5 IMMUNIZATION OF CHILDREN AND MOTHERS

Vaccinating children with measles, tetanus, diphtheria, pertussis, polio, BCG and hepatitis B vaccines is part of the routine Expanded Programme on Immunization (EPI) schedule. To ensure protection among newborns against tetanus, the mother should have received two doses of tetanus toxoid vaccine during the recent pregnancy, or at least three doses of tetanus toxoid in the past. In some countries and areas, additional vaccines may be available through the routine EPI schedule. Vitamin A and deworming may also be delivered with immunization, and use of insecticide-treated bednets should be promoted during immunization sessions.

4.6 INTEGRATED MANAGEMENT OF SICK CHILDREN

Management of pneumonia, diarrhoea and malaria requires an integrated approach. Assessing the whole child during a consultation will allow the identification and treatment of all major conditions such as pneumonia, diarrhoea, malaria and other febrile conditions as well as undernutrition. It will also prompt referral as necessary.

Pneumonia in children requires treatment with antibiotics. The standard case management of diarrhoea includes oral rehydration therapy with low-osmolarity oral rehydration salts (ORS) solution along with zinc; whereas antibiotics are indicated for dysentery only. In most malarious areas of the Region, falciparum malaria is treated with artemisinin-based combination therapies due to high multidrug resistance. Due to the high cost of this treatment,
it is important that there is a blood-sample-based diagnosis with microscopy or rapid diagnostic tests. Vivax malaria can cause severe morbidity and should also be diagnosed and treated. Treatment of both falciparum and vivax malaria should follow national guidelines.

A continuum of care must be emphasized where case management occurs in the community, at first-level health facilities and at referral hospitals. Different combinations of interventions will be available at each delivery point. Referrals to hospitals are necessary for children with severe pneumonia, diarrhoea and malaria as well as with other severe conditions.

4.7 USE OF INSECTICIDE-TREATED BEDNETS

In malarious areas, insecticide-treated bednets should be available as a preventive intervention for malaria. For vulnerable populations living in remote areas, long-lasting insecticide-treated nets have an advantage over insecticide dipping of conventional nets.

<table>
<thead>
<tr>
<th>Estimated cost of main commodities for child survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Breastmilk is free</td>
</tr>
<tr>
<td>• 10¢ for all Vitamin A supplements required in childhood</td>
</tr>
<tr>
<td>• $15-$17 to immunize a child against seven major childhood diseases</td>
</tr>
<tr>
<td>• 20¢ for a three-day course of oral antibiotics for pneumonia</td>
</tr>
<tr>
<td>• $3-$6 for a long-lasting impregnated bednet to prevent malaria</td>
</tr>
<tr>
<td>• 50¢ for 10 packets of ORS to prevent dehydration in children with diarrhoea, and 20¢ for a ten-day treatment with zinc</td>
</tr>
</tbody>
</table>
5 Actions that strengthen the essential package

5.1 IMPROVEMENTS IN WATER, SANITATION AND THE ENVIRONMENT

Increased access to safe water supply with increased quantity of water for personal and environmental hygiene and improved sanitation with safe disposal of faeces are included in MDG 7 and are important to realize MDG 4. Additional actions to create safe home and community environments, clean air free from indoor and outdoor air pollution (including solid fuel use), and safe food will augment the essential package for child survival.

5.2 BIRTH SPACING

An estimated 38% of all pregnancies occurring globally each year are unintended, and more than one half of such pregnancies result in induced abortions. Families require access to good reproductive health care as evidence has shown increased risk of infant mortality after short preceding birth intervals. Children born three to five years after a previous birth are about 2.5 times more likely to survive their infancy than children born earlier.

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5.3 PROMOTING GENDER EQUALITY, EMPOWERMENT OF WOMEN AND WOMEN’S EDUCATION

Gender gaps are widespread in access to and control of resources, as well as in economic opportunities, power and political voice. Promoting gender equality is an important part of any development strategy that enables both women and men to escape poverty and improve their standard of living. Economic development paves the way for increasing gender equality over the longer term. However, this must be coupled with an environment that provides equal opportunities for women and men, and policy measures that address persistent inequities. Evidence has shown that empowering women through education is likely to benefit the health of their children.

5.4 PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

Most countries and areas in the Region have an increasing problem with HIV/AIDS. The countries and areas with a high prevalence should prioritize prevention of mother-to-child transmission (PMTCT) of HIV, including primary prevention, voluntary counselling and testing, care and support for HIV-positive mothers. In areas where HIV is a significant public health problem, all women must be assured access to confidential testing for HIV. If a mother is HIV-infected and replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life. Drug treatment for PMTCT of HIV may be available in some countries and areas in the Region.
6 Strategic approaches for child survival

It must be recognized that “more of the same” will not lead to the achievement of the objectives of this strategy. While interventions necessary to save children’s lives are well known and tested, the health systems through which they must be delivered are increasingly complex and continually changing. Therefore, the process by which these interventions are implemented will require innovation, flexibility and renewed commitment.

WHO and UNICEF have joined forces to show unified commitment to one direction in child survival under the leadership of the governments in the Region. Engagement of other United Nations organizations, multilateral development banks, and bilateral agencies is important to ensure an enabling environment for child survival.

6.1 IMPROVING LEADERSHIP AND GOVERNANCE

Policy-makers in different government sectors must provide strong and consistent leadership. Accelerating child survival efforts will require leadership from influential political figures at the highest possible level. To ensure wide support and that children’s rights to health and health care are addressed, highly visible and well-respected champions will be needed across different sectors of society.

Accelerated action may necessitate changes in policy, laws and regulations and will require clear guidance across all relevant sectors. Ensuring that responsibilities are assumed and acted upon will require good governance that involves national assemblies, ministries of finance, planning and investment, health, education, agriculture, labour, justice and social affairs, as well as local governments and state-run media. Non-governmental institutions such as political parties, the media, professional associations, religious leaders, rural cooperatives, community-based organizations, civil society organizations and the private sector each play complementary roles.
A high-level national body should coordinate planning for child survival actions. Not only will this approach promote improved coordination between various Ministry of Health departments, such as maternal and child health, communicable diseases, nutrition, and human resources but also with all relevant stakeholders from other governmental sectors including finance, education, agriculture and legislation.

6.2 CONSOLIDATING PARTNERSHIPS

Efforts of various existing child-health related programmes should be synchronized to maximize impact. All activities should build upon what the country has already initiated in child health with a focus on overcoming difficulties. Roles and responsibilities should be defined and collaboration among all stakeholders strengthened to ensure resource pooling and to avoid duplication of efforts.

New partnerships may be established by involving the academic community and professional associations as influential partners in child survival for advocacy and leadership, and to inform national strategic direction, policies, education and research.

Strengthening partnerships with international and local nongovernmental organizations (NGO), for example, women’s and youth unions, is essential, especially to forge strong links with communities. Partnership with the private sector should be explored to identify possible ways to utilize its services to maximize child survival efforts.

The Partnership for Maternal, Neonatal and Child Health has been established at the global level. In certain countries, it may be useful to call on the support of this partnership to bring greater attention to the need for increased resources and action for child survival.
6.3 IMPROVING EFFICIENCY AND QUALITY OF SERVICE DELIVERY

The principles of primary health care form the foundation for implementing the essential package for child survival, while the specific approaches taken to achieve accelerated and sustained action towards MDG 4 will depend on the capacities of health systems. All available delivery points for child survival interventions should be exploited at various levels. In the community, these include commodity retailers, pharmacies, drug sellers, community health workers and outreach services. Some interventions can only be delivered through outpatient and inpatient health facilities. The public, charitable or for-profit private sectors can all provide services.

6.3.1 DELIVERING ESSENTIAL INTERVENTIONS AT THE COMMUNITY LEVEL

Where health facilities are scarce or poorly utilized, community-based and outreach services should be promoted to deliver interventions selected according to the prevailing diseases. This might require adjustments to health system policies such as adopting a list of non-prescription drugs that can be delivered in the community. For example, ORS and zinc could be made available in communities through the public system or through the private sector, including through social marketing.

Community-level case management of uncomplicated pneumonia, diarrhoea, malaria and neonatal sepsis has proven to be feasible and effective in reducing mortality.10, 11 This requires community health workers who are formally authorized to carry out these tasks, adequately trained and supervised. Use of antimicrobial drugs at this level may require programmatic and legislative changes. If community health workers are used, thorough planning is required for their training, recruitment, placement, supervision and motivation. Delivery of child survival interventions through the private sector, including social marketing, also requires a clear supportive regulatory framework.

Interventions such as immunization and vitamin A capsule or bednet distribution are sometimes most effectively delivered through outreach services. Outreach is most efficient if delivery of several interventions is integrated and takes advantage of existing services, for example of immunization. Outreach services have considerable health system implications including human resource planning, training and incentives as well as logistics.

6.3.2 SERVICE DELIVERY AT THE HEALTH FACILITY LEVEL

Facility-based service delivery, both preventive and curative at the primary and referral levels, is at the core of most health systems. Interventions to be delivered for child survival must be clearly defined, along with quality standards that can be monitored and supported by adequate supplies and equipment. Human resources need to be appropriately trained, distributed, remunerated, supervised and authorized to deliver the full essential package for child survival. For example, nurses may need to deliver antimicrobial drugs in order to ensure rapid life-saving treatment. Appropriate referral mechanisms that remove or reduce financial and other barriers to referral and hospital care are also critical to saving lives.

Involvement of the communities in health service planning and provision strengthens provider responsiveness, particularly towards the poor and marginalized. It can improve the functioning of facilities and the quality of care leading to increased demand and utilization of services.

The essential child survival interventions should be promoted and delivered through integrated approaches. These include the Integrated Management of Childhood Illness (IMCI), Making Pregnancy Safer (MPS) through the Integrated Management of Pregnancy and Childbirth (IMPAC) and the Infant and Young Child Feeding (IYCF) strategy. Integrated case management approaches are not only cost-effective but also reflect best clinical practice.

Functional hospital care is important to reduce mortality from severe illness. Hospital-level approaches to implementing elements of the essential child survival interventions include the Baby Friendly Hospital Initiative and guidelines and activities to improve the quality of paediatric hospital care. These strategies need to be pursued and strengthened.
6.4 ENGAGING AND EMPOWERING FAMILIES AND COMMUNITIES

The potential of family and community practices to improve child survival has been well demonstrated. Most of the care of childhood illness occurs in the home; to improve this care families may need to change their behaviours. Though difficult, this can be accomplished by repeatedly providing information, education and communication to families through different channels including mass media, community and religious leaders, and health workers. Improving health worker skills in counselling and working with peer-educators and community groups is essential. Coordinated efforts with these partners can help ensure consistency of messages.

Empowering families, particularly women, facilitates decision-making in relation to care of their children. One of the most critical decisions is when to take a sick child for health care. Families need to be taught to recognize the danger signs that indicate that immediate consultation with a health worker is needed.

Emphasis must be placed on creating an educated demand for services and empowering families through methods that give them a voice in determining the quality and characteristics of the services. This becomes the foundation of communication strategies that are developed with and by the community to serve the community’s self-expressed needs.

Communities need to know what is appropriate preventive and curative care for children and what they should expect from health services. They should be provided with information on changes in the core indicators for child survival for their area so that they can become advocates for improvement.

Sustainable change in family practices will be more likely when communities are actively involved in the planning, implementation and monitoring of health promotion and health care activities. The Integrated Early Childhood Development (IECD) strategy promoted by UNICEF is one approach to ensure all elements of community action for child survival, growth and development are put in place together.
6.5 ENSURING HEALTH CARE FINANCING SUPPORT FOR CHILD SURVIVAL

Actions to increase budgetary spending for health by 1% of the gross national product by 2007 and 2% by 2015 compared with levels of spending in 2001 in low and middle-income countries should be pursued as part of a comprehensive national policy on health care financing. Health care financing mechanisms that aim to reduce financial barriers to health care support the right of every child to health and health care.

It is important that child survival interventions funded by different financing mechanisms should increase the utilization of the essential package. Broadly speaking, these mechanisms include tax-based systems, social health insurance, private health insurance including community-based health insurance, or mixes of these. The objectives of equity and pro-poor financing should guide the design of the social protection schemes selected. Policy-makers should aim at including children among the direct beneficiaries in these schemes. Key child survival interventions should be included in the essential package of health services guaranteed to the population. This may be particularly relevant in poorer populations. One should also aim that the essential package of child survival interventions should be free of any charges at the point of use. Subsidizing the production and sale of commodities with high child survival impact, such as bednets, ORS and fortified food should also be considered. An important outcome may be life-saving and timely care seeking for childhood illnesses.

The government stewardship role needs to be strengthened to use all available resources (both government and nongovernmental) effectively for enhancing child survival. Child health should also be incorporated as a priority within Poverty Reduction Strategies, Medium-Term Expenditure Frameworks, Sector-Wide Approaches, Socio-Economic Development Plans and other planning, financing and coordination instruments. These increasingly guide national poverty reduction and development efforts and external financing.
7 Addressing diversity and inequity across and within countries

7.1 DIVERSITY OF COUNTRIES AND AREAS IN THE REGION

Countries and areas of the Region vary greatly in terms of their health-related parameters relevant to child survival, for example child mortality rates, the composition of the causes of death including the proportion of deaths that occur in the neonatal period, the prevalence of underlying risk factors, and the level of health system development.

Responding to diversity requires a range of approaches. For the purpose of this regional strategy, countries and areas have been categorized into three groups based on their child survival-related parameters. The three groups are shown in the following map.

Figure 6: Category of countries in relation to child survival
In Group 1 countries, infectious diseases and undernutrition remain prominent throughout most of the population. Group 2 countries have improving economic growth and often mid-range development indicators. Significant areas in these countries, however, have conditions similar to Group 1 countries, while in other areas, a transition away from infectious diseases is occurring. In the latter, there are proportionately more deaths due to neonatal and non-infectious causes, including unintentional injuries. In Group 3 countries, the epidemiological transition is nearly complete with far fewer deaths. Mostly marginalized populations suffer from infectious diseases and undernutrition. There are fewer perinatal deaths since most deliveries are institutional and other causes like injuries and drowning, congenital and genetic abnormalities become proportionately more important.

Analysis of subnational data on child mortality and its causes is especially important in Group 2 and Group 3 countries to detect geographic areas and pockets of population where the situation differs from the national averages.

As earlier indicated, this strategy focuses on the essential package for child survival. Table 1 lists the countries and areas under the three groups and suggests how the emphasis of child survival actions might vary from group to group. The interventions listed in bold typeface represent the priority interventions that, if implemented, are likely to create the greatest improvement in child survival indicators in these countries. The other interventions may be undertaken by individual countries and areas, or portions of those countries and areas, as resources permit. Though these will make some impact on child survival, it is not likely to be as great as the impact of the interventions in bold.
### Table 1: Child survival actions by country group

<table>
<thead>
<tr>
<th>Group</th>
<th>Countries/areas</th>
<th>Child survival strategy emphasis (priorities are in <strong>bold</strong>)</th>
</tr>
</thead>
</table>
| 1     | Cambodia, Kiribati, Marshall Islands, Lao People’s Democratic Republic, Papua New Guinea, Solomon Islands, Vanuatu | • Essential package for child survival  
• Deworming of children 6-59 months and pregnant women |
| 2     | China, Fiji, Micronesia, Mongolia, Nauru, Philippines, Samoa, Tonga, Tuvalu, Viet Nam | • Essential package for child survival with geographic targeting in underserved areas  
• Institutional deliveries with comprehensive newborn care  
• Deworming of children 6-59 months and pregnant women  
• Promotion of childhood safety  
• Introduction of new or underused vaccines: *Haemophilus influenzae* type B, rotavirus, conjugate pneumococcal vaccine |
| 3     | American Samoa, Australia, Brunei Darussalam, Cook Islands, French Polynesia, Guam, Hong Kong (China), Japan, Korea, Republic of Malaysia, Macao (China), New Caledonia, New Zealand, Niue, Northern Mariana Islands, Palau, Singapore, Tokelau, Wallis and Futuna | • Essential package for child survival with targeting of the socioeconomically under-privileged and marginalized  
• Institutional deliveries with comprehensive newborn care  
• Promotion of childhood safety  
• Introduction of new or underused vaccines: *Haemophilus influenzae* type B, rotavirus, conjugate pneumococcal vaccine |
7.2 ADDRESSING INEQUITY

This strategy aims to accelerate and sustain action towards reaching MDG 4 by implementing an essential package for child survival with universal coverage. The strategy will be successful in reducing inequity only if interventions reach the poorest and most marginalized households of all countries of the Region. This includes those marginalized by geographical, social, political, economic, ethnic and gender factors.

Achieving universal coverage of the essential package is a considerable challenge and takes time. In Group 1 countries where most households have a low income, achieving universal coverage of the essential package will reduce inequities in child survival. Because overall coverage levels in these countries are low, there is no point in targeting interventions at this stage. On the other hand, targeting of the poor households in Group 2 and Group 3 countries and areas is recommended while striving for universal coverage for all children. If pro-poor approaches are used, they need to be implemented at high coverage to be most successful.

To assess equity in the context of child survival, intervention coverage needs to be measured by socioeconomic groups (usually quintiles). Data from large surveys such as Demographic and Health Survey (DHS) or Multiple-indicator Cluster Survey (MICS) can be used for this purpose. This approach would present strong advocacy for delivering child survival interventions to those most in need. Equity monitoring will require repeated large surveys every four to five years.
8 Monitoring and evaluation of child survival activities

8.1 MONITORING IMPLEMENTATION

Regular monitoring of the coverage of child survival interventions is important so that implementers and decision-makers can measure progress and identify problems to be addressed. Ten core indicators for child survival are shown in Table 2.

<table>
<thead>
<tr>
<th>Components of essential package</th>
<th>Core indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Skilled attendance during pregnancy, delivery and the immediate postpartum</td>
<td>1. Proportion of births assisted by skilled health personnel</td>
</tr>
<tr>
<td>2 Care of the newborn</td>
<td>2. Proportion of infants less than 12 months of age with breastfeeding initiated within one hour of birth</td>
</tr>
<tr>
<td>3 Breastfeeding and complementary feeding</td>
<td>3. Proportion of infants less than 6 months of age exclusively breastfed</td>
</tr>
<tr>
<td>4 Micronutrient supplementation</td>
<td>4. Proportion of infants 6-9 months of age receiving breastmilk and complementary food</td>
</tr>
<tr>
<td>5 Immunization of children and mothers</td>
<td>5. Proportion of children 6-59 months old who have received vitamin A in the past 6 months</td>
</tr>
<tr>
<td>6 Integrated management of sick children</td>
<td>6. Proportion of one-year-old children immunized against measles</td>
</tr>
<tr>
<td>7 Use of insecticide-treated bednets</td>
<td>7. Proportion of one-year-old children protected against neonatal tetanus through immunization of their mothers</td>
</tr>
<tr>
<td>8 Proportion of children 0-59 months of age who had diarrhoea in the past 2 weeks and were treated with ORT</td>
<td>8. Proportion of children 0-59 months of age who had diarrhoea in the past 2 weeks and were treated with ORT</td>
</tr>
<tr>
<td>9. Proportion of children 0-59 months of age who had suspected pneumonia in the past 2 weeks and were taken to an appropriate health care provider</td>
<td>9. Proportion of children 0-59 months of age who had suspected pneumonia in the past 2 weeks and were taken to an appropriate health care provider</td>
</tr>
<tr>
<td>10. Proportion of children 0-59 months of age who slept under an insecticide-treated net the previous night</td>
<td>10. Proportion of children 0-59 months of age who slept under an insecticide-treated net the previous night</td>
</tr>
</tbody>
</table>

WHO and UNICEF at the global level have agreed on a minimal set of key indicators for monitoring progress towards child survival. The ten core indicators for child survival are in agreement with this list.
Countries and areas of the Region should measure baseline values for core indicators and then repeat measurements on a yearly basis. Wherever possible, the monitoring system should build on existing and planned national monitoring tools. Coordination and collaboration with programmes with well-developed monitoring systems, such as EPI, would assist this approach. While it is important to strengthen the routine monitoring system in all countries, many will be reliant on period surveys to obtain data. Consideration should be given to adopting sentinel sites to conduct facility and household surveys every year or two if there is no standard system in place. A possible option is to carry out these frequent surveys with relatively small samples to obtain nationally representative coverage data, and to carry out larger surveys, say every four or five years, as proposed in section 8.2. Monitoring activities should be included in programme implementation plans with at least 5% of total budget for child survival allocated for this purpose.

In addition to monitoring the implementation of interventions, it is important to measure resource flows to child survival activities and the impact of health care financing mechanisms. The amount and proportion of government health spending on child health should be monitored annually. Similarly, the cost to the health system and to families of the key interventions should be monitored to ensure that they remain affordable to those who need them. The analysis of monitoring results should include both health indicators and financing indicators.

8.2 EVALUATION

Periodic evaluations, every five years or more frequently, of the status and impact of child health interventions on mortality, undernutrition and equity should be conducted. This requires large-scale population based surveys, such as DHS or MICS that have the capacity to measure the MDG and other indicators, including under-5, infant and neonatal mortality rates, underweight and stunting, in addition to the ten core indicators and other standard indicators routinely included in these surveys. Surveys should be complemented by programme reviews that identify best practices, as well as constraints and ways to overcome them. When possible the surveys and reviews should be performed in collaboration with independent third-party institutions.

Monitoring and evaluation data should be disaggregated according to socioeconomic quintiles, age, gender, ethnicity, and location (subnational) in order to measure progress towards reducing inequity. Results should be made widely known to collaborating government sectors, implementing partners and the community, and used to improve the content and targeting of the strategy. Progress towards child survival country targets may be utilized as an advocacy tool.
WHO/UNICEF
Regional Child
Survival Strategy
Accelerated and
Sustained Action
Towards MDG 4

9 The way forward: organize and mobilize

“The Three Ones, Plus Two”

- One coordination mechanism
- One national plan
- One monitoring and evaluation process
- Mobilize for advocacy and communication
- Mobilize financial resources to accelerate and sustain progress

9.1 ONE COORDINATION MECHANISM

Stronger leadership for child survival is needed among governments, collaborating partners, academics, NGOs and civil society organizations. Strong child survival advocates must be developed and promoted to place child survival firmly on the political, economic and health development agenda. A national body, led at the highest possible political level, should be established to coordinate planning for child survival actions at country level. This body should include active participation from all relevant sectors and stakeholders. The composition should depend on the situation in each country. Experience suggests that this body will need to be directed by a level higher than the Ministry of Health if it is to achieve the necessary acceleration in child survival.

9.2 ONE NATIONAL PLAN

Countries should ensure that child survival is included in national plans of action for children or they should develop a national strategic plan specifically for child survival. National plans should be developed with multi-stakeholder participation. These should
show clearly where child health fits into the overall health agenda, and where the health agenda fits into the development framework of the country, including national socioeconomic development plans and poverty reduction strategy.

The level of detail for planning should be adjusted to the needs and capacities of the country. Some countries may be able to prepare and implement relatively sophisticated and comprehensive plans. Others should focus on simple matrices of milestones to be achieved in each area of activity each quarter. This will ensure that the plan stays relevant and can be adjusted and closely monitored.

National plans must be linked to credible levels of funding from government and external sources. They should include aspects of human resources development and health system strengthening needed for child survival at national and subnational levels but cannot take on the full burden of reforming health systems.

9.3 ONE MONITORING AND EVALUATION PROCESS

Chapter 8 above outlines the needs for monitoring and evaluation. It is critical that these are met through one single monitoring and evaluation process to which all stakeholders adhere. This is essential to avoid duplication of effort, ensure comparability and use of standard indicators, and enable the government to assume its role of oversight of child survival activities and progress.

9.4 MOBILIZE FOR ADVOCACY AND COMMUNICATION

In order to mobilize all concerned, emphasis must be placed on increasing awareness for child survival within the greater community, including village leaders, parents, teachers, the media and private sector. Respected national figures and prominent stars of sports and entertainment may be engaged as champions for child survival and to give children a voice. All available channels for raising the profile of child health should be used through the development and dissemination of advocacy materials. Greater emphasis needs to be made on community-derived communication strategies that reflect local ideas and beliefs about child survival.

In order for this to happen each country should prepare a child survival advocacy plan and ensure that resources are devoted to implementing it. This may be a critical first step in drawing further resources to child survival efforts.
9.5 MOBILIZE FINANCIAL RESOURCES TO ACCELERATE AND SUSTAIN PROGRESS

To achieve MDG 4 in the Region massively increased investments in child health will be required through increased government spending and external assistance. To achieve and sustain adequate and stable financing for child health, there needs to be stronger political commitment to increased government resource allocation. In some countries, however, it is not realistic to think that the considerable additional needs can be met within the government health budget. For the poorer countries of the Region, only a significant increase in external funding will achieve the increase in effort needed.

Estimates of resource requirements should be made based on credible costing. The absence of detailed costing analyses cannot, however, be used as an argument not to increase patently inadequate funding.

While this strategy does not promote the creation of a separately financed child health system, it does advocate for financing that is adequate to ensure that child health outcomes are improved, sustained and equitably delivered. More balanced allocation and coordinated use of existing external resources (such as that for tuberculosis, malaria and HIV/AIDS) would help in this regard.

As outlined in section 8, monitoring of resource flows to child survival is important. Child health funding flows should be reflected in the National Health Accounts where they exist. More and better data on funding for child survival will be needed to ensure accountability and monitor the commitment to child health.
SUMMARY NOTE

Clearly, putting in place “the three ones, plus two” is only one step in the accelerated and sustained process of reducing child survival to achieve the MDG targets by 2015. Nevertheless it is important that these elements are quickly implemented as soon as this strategy is adopted. They form the foundation for ensuring action to save children’s lives.
Annex 1

WPR/RC54.R9 CHILD HEALTH

The Regional Committee,

Recalling resolution WHA56.21 on the strategy for child and adolescent health and development;

Recognizing that, despite overall progress in reducing child mortality in the Region, in the past decade progress has stalled or even been reversed in some countries;

Further recognizing that differences in the child survival rates in countries and areas in the Region are widening;

Concerned about the unacceptably high number of children that die from preventable and treatable conditions before they reach their fifth birthday;

Reaffirming the commitment of Member States to the attainment of a two-thirds reduction in under-five mortality by the year 2015 compared with 1990, in line with the development goals of the United Nations Millennium Declaration and the United Nations General Assembly special session on children;

Aware that Article 24 of the Convention on the Rights of the Child calls on Member States to implement measures to reduce infant and child mortality, ensure the provision of necessary medical assistance and health care to all children, and combat disease and malnutrition;

Acknowledging that international cooperation will be needed if children’s rights are to be fully realized, particularly in developing countries;

Noting that interventions are available to reduce child and infant mortality and that the Integrated Management of Childhood Illness (IMCI) is an evidence-based strategy that delivers these interventions in an effective, efficient and equitable manner, by focusing on the major threats to children’s survival, growth and development;

Further noting that similar delivery strategies could benefit the health of newborns;

Acknowledging that IMCI has been endorsed by major development partners as a cost-effective strategy for improving children’s health;

Noting the need for strategic coordination among the various donor partners involved in child health activities at the national level;

Appreciating the progress made so far in implementing IMCI in the Region and the urgent need to scale-up interventions in order to achieve the desired child health outcomes;
1. **URGES Member States, in particular those with high child mortality:**
   
   (1) to place child health higher on their political, economic and health agendas, to protect every child’s inherent right to life, and to ensure the provision of health care and medical assistance to all children in need;
   
   (2) to target child survival interventions on geographical areas and segments of society with the highest burden of childhood mortality and morbidity;
   
   (3) in countries implementing IMCI, to prioritize, strengthen and scale-up implementation of the strategy and, utilizing all available sources of finance, to provide adequate human and financial resources for the full implementation of IMCI;
   
   (4) to strengthen national health systems and service delivery, and, where appropriate, to include IMCI in ongoing and planned health sector reform efforts;
   
   (5) to designate, where appropriate, a national coordinating body responsible for planning, implementation, monitoring and evaluation of child health activities, including IMCI;

2. **REQUESTS the Regional Director:**
   
   (1) to continue to support Member States to achieve internationally agreed goals and targets for the reduction of under five mortality, especially in countries and areas with marginalized and poor populations with high infant and under-five mortality;
   
   (2) to develop indicators to assist Member States to monitor progress towards the achievement of the development goals of the United Nations Millennium Declaration;
   
   (3) to give priority to child survival and, in particular, to intensify implementation of IMCI in the Region;
   
   (4) to promote collaboration among child-health-related programmes and partners in health;
   
   (5) to stimulate the development of health care delivery strategies that are consistent with IMCI to improve the health of newborns;
   
   (6) to lead a new drive to reduce childhood mortality in Member States in greatest need, to support these countries to mobilize the resources needed, and to report on progress to the Regional Committee.
Annex 2

WPR/RC56.R5 CHILD HEALTH

The Regional Committee,

Concerned about the unacceptably high number of children who continue to die from conditions that could be prevented or treated with existing, cost-effective and evidence-based interventions;

Recalling resolution WPR/RC54.R9 to position child health higher on political, economic and health agendas and provide financial resources to match the burden of disease in children;

Reaffirming the commitment of Member States to attain the Development Goals of the United Nations Millennium Declaration pertaining to child survival and health;

Mindful of the Convention on the Rights of the Child which calls on States Parties to ensure the fulfilment of children’s rights to survival, health and the treatment of illness;

Recalling resolution WHA58.31 on working towards universal coverage of maternal, newborn and child health interventions;

Praising the commitment of WHO and UNICEF to adopt a unified direction in providing support to countries and areas of greatest need in accelerating child survival efforts, and encouraging other partner agencies to join in this endeavour;

Having reviewed the draft WHO/UNICEF Regional Child Survival Strategy;

Reaffirming the moral, political and economic imperative to prioritize the survival of children in the Region,

1. ENDORSES the WHO/UNICEF Regional Child Survival Strategy;

2. URGES Member States:

(1) to demonstrate political commitment in urgently establishing, where appropriate, a national coordinating body at a high level for action to improve child survival and health;

(2) to immediately initiate preparations for review and/or development of national policies and strategies, and for implementation plans at all levels for child survival and its accompanying monitoring and evaluation mechanisms;

(3) to mobilize adequate resources for the full implementation of child survival activities embedded in these policies and plans, considering all possible sources;
(4) to use the WHO/UNICEF Regional Child Survival Strategy as a guide for action to reduce inequities in child survival and to reduce child mortality in the countries and areas of the Region in line with the fourth goal of the Development Goals of the United Nations Millennium Declaration;

(5) to ensure close collaboration with maternal health in child survival activities,

3. REQUESTS the Regional Director:

(1) to support Member States in their efforts to improve child health, mobilize resources and facilitate the implementation of the WHO/UNICEF Regional Child Survival Strategy;

(2) to work with Member States in monitoring and evaluating the effects of actions taken;

(3) to collaborate with UNICEF and other partners in the implementation of the WHO/UNICEF Regional Child Survival Strategy;

(4) to convey to members of the Executive Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria the need for child health and survival to be given appropriate emphasis by the Fund, within its mandate;

(5) to report progress to the Regional Committee commencing at the fifty-eighth session.