

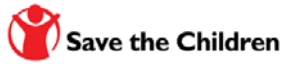


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CHILD SURVIVAL
CALL to ACTION
Ending Preventable Child Deaths

Summary Roadmap

Version 1
June 14, 2012



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Contents

- Overview 3
- The Road Ahead..... 6
- Establishing a Baseline: Where We Are Today 7
- How to Get Every Country to at Least 20 by 2035: Five Strategic Shifts 9
- Reaching 2015 and Beyond 17
- References..... 18

OVERVIEW

This year, more than 7 million children – most of them in sub-Saharan Africa and South Asia – will die before they celebrate their 5th birthday. They'll never graduate from university, they'll never begin a career, and they'll never start a family of their own. They will never have the opportunity to fulfill their potential or contribute to the progress of their own families, communities, or countries.

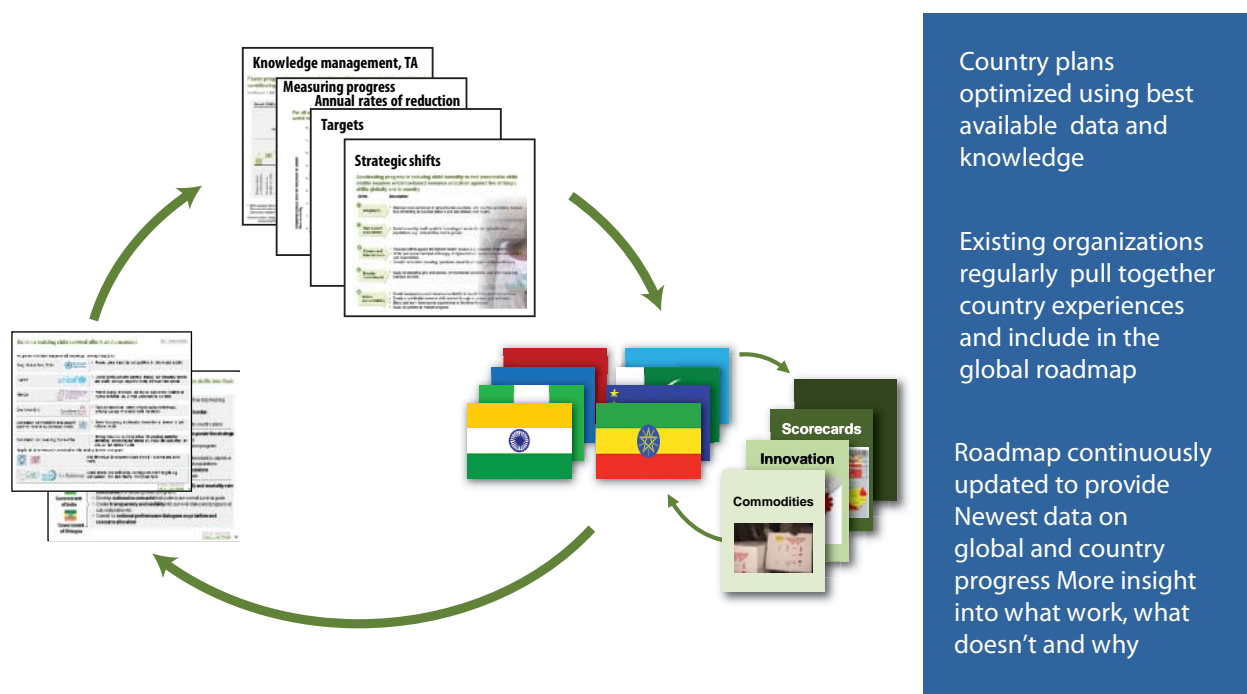
Over the last 50 years, we've seen extraordinary progress as child mortality rates around the world have declined by 70 percent. In just the last 20 years, we've cut the number of annual child deaths by 4.4 million. That progress has been inspiring, occurring in some of the poorest and most disadvantaged countries in the world. But, it is not enough.

Based on current rates of progress, many countries will not achieve Millennium Development Goals (MDGs)

4 and 5 to reduce child mortality and improve maternal health. And around the world, we see a glaring disparity between the rate of child deaths in rich countries and poor countries, between rich families and poor families – disparities that will persist well into the next century unless the world takes action.

But for the first time in history, we have the tools and the knowledge to change that trajectory. With new partners, a change in focus, and a global commitment to hold ourselves accountable, **we can bring an end to preventable child deaths.** Taking on the challenge of ending preventable child deaths won't just save millions of lives. It will also help countries accelerate their economic growth and social development. It will unlock billions in economic savings by reducing the burden of disease and the cost of treating illness. By leaving couples confident that their children will survive to adulthood, it will free them to have smaller families, creating favorable demographic shifts that can lead to an economic dividend. And by encouraging investments in good governance, gender equality and equitable access

Figure 1. The Global Roadmap will capture the specific goals, state of knowledge, and progress of child survival, as it evolves through the leadership of countries and other stakeholders.



to care, it will help every country address equitably the needs of its people.

Ultimately, ending preventable child deaths requires a new way forward: a dynamic Global Roadmap for action. By building a shared vision of how to end preventable child deaths, this Global Roadmap can build consensus around where the world stands each year, what progress has been made, and what all countries and partners can do in the future to achieve their national targets.

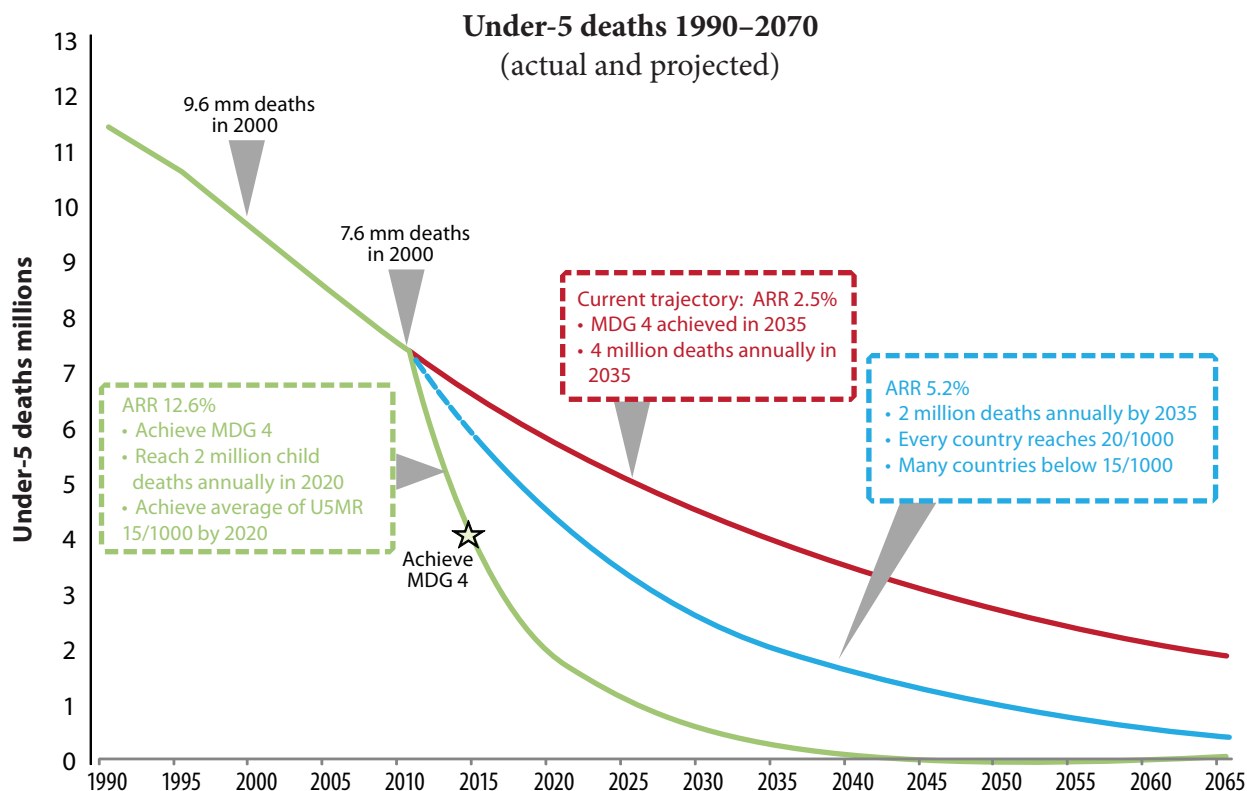
This first iteration of this Global Roadmap pulls together the world's current knowledge about child deaths, drawing on the latest, peer-tested statistics and modeling of the global health community. It presents realistic projections about current rates of progress in the fight against preventable child deaths and where they may fall short. It proposes clear, ambitious and achievable targets for governments, civil society, private sector partners and donors to discuss. It highlights the most recently available data and analyses on child survival trends and the impact of the latest interventions, demonstrating how the global community can accelerate progress.

Finally, this Global Roadmap – and the Child Survival Call to Action – highlight commitments and actions by leaders who champion the goal of ending preventable child deaths. As countries continue to make progress in their efforts and as new approaches are tried, the Global Roadmap should be updated to reflect new realities and the latest knowledge, including lessons learned from the evolving experience of countries and partners. Eventually, the Global Roadmap should evolve into a Global Implementation Plan, built upon the foundation of national plans and observed progress (Figure 1).

Highlights from this Global Roadmap include:

- **Twenty-four countries account for 80 percent of under-5 child deaths and of these, five countries – India, Nigeria, Democratic Republic of the Congo, Pakistan, and Ethiopia – account for almost 50 percent of global under-5 mortality.** Dramatically reducing the number of child deaths requires a special focus on these countries, especially the leading five. Government, civil society, and private sector leaders in these countries should be supported as they define their own country roadmaps and targets, commit their own financial resources, and pioneer new ways to accelerate progress toward ending preventable child deaths.
- **Large inequalities in child survival persist and in some countries are growing.** Countries need to refocus their health systems on scaling up access to high quality services for populations suffering from a disproportionate burden of disease, especially rural, poor, and marginalized populations. And, they need better mechanisms to actually measure the impacts of the health care they receive.
- **Each country should target the causes and solutions that will have greatest impact on accelerating progress against the rate of child deaths.** The demand for, and supply of, the highest-impact, evidence-based interventions and commodities must be taken to scale and sustained. The world now knows what kills children and what interventions along the continuum of care can save them. What we must invest in is sustainably taking these interventions to scale. Continued innovation in technologies and approaches is critical.
- **More attention is needed to address the largest, most persistent causes of child mortality, specifically neonatal conditions, which account for 40 percent of child deaths.** New tools and approaches such as simple interventions to prevent birth asphyxia are changing what is possible, but greater innovation and focus is needed.
- **Ending preventable child deaths will require more than successful implementation of health interventions; it will also mean investing in educating girls, empowering women,**

Figure 2. Accelerating the progress on child survival – what can the world achieve if countries increase their annual rate of reduction?



Source: UNICEF State of the World's Children 2012; The UN Inter-agency Group for Child Mortality Estimation, Levels and Trends in Child Mortality: Report 2011, 2011; Team analysis from 2035 onward based on straight-line ARR reduction from UNICEF numbers 1990-2035

delivering inclusive economic growth, improving sanitation and hygiene, and overcoming inequalities. Progress in child survival is one of the best measures of how well a government is meeting the needs of its people, and increased rates of child survival reflect a national commitment to invest in equitable social and economic progress.

- **Newborn, child, and maternal survival is the responsibility of every country and every partner.** We must all commit to greater transparency and mutual accountability for results at the global, regional, country, and community levels. The call for child survival will only be successful if we share a common commitment toward a common goal. Country experiences in the fight against child deaths need to be shared, and

greater investments must be made in systems to monitor progress through regional and country scorecards.

- **Many leaders are already prepared to hold themselves and each other accountable for targets and results in the effort to end preventable child deaths.** They are willing to commit to greater transparency and demand more timely and sensitive data. It is a trend all leaders should embrace.

To advance Every Woman Every Child, a global movement launched by the U.N. Secretary-General, UNICEF and other U.N. agencies invite partners from the public, private, and civil society sectors, as well as relevant global alliances, to join **Committing to Child Survival: A Promise Renewed** by pledg-

ing to pursue the clear and compelling goal to end preventable child deaths.

THE ROAD AHEAD

Sharing a vision and a target

The first step along the road toward a better future for millions of children in the developing world is setting a clear, equitable, and achievable vision: ending preventable child deaths.

Setting this new vision provides an opportunity to accelerate progress toward achieving MDGs 4 and 5 – reducing child mortality and improving maternal health – by 2015. It will also rightly keep the focus on the millions of children that will continue to die unnecessarily in 2016 and beyond. And, it will provide a unified vision and encourage coordinated action from the global health community during the post-2015 dialogue that will determine which challenges are elevated to global attention.

By setting a vision of every country reaching 20/1000 or below by 2035, the world would reduce child deaths to fewer than 2 million per year, preventing tens of millions of children from dying. **The key question is how fast can the world accelerate progress to achieve that vision?**

If countries can accelerate the rate of child mortality reduction to about 12.5 percent annually, they can not only achieve MDG 4, but also they can bring the total number of child deaths down to 2 million by 2020, saving 5 million lives annually (Figure 2). Accomplishing that would mean children born anywhere in the world in 2020 would have a much closer chance of surviving until age 5. If the world can't sustain that level of progress, an annual rate of reduction of 5.2 percent would mean we could still achieve that goal of all countries below 20/1000 in a generation, in 2035 (UNICEF, 2011, 2012; UN, 2011). Based on the current trajectory – an annual rate of reduction of 2.5 percent – that goal would not be reached until 2062, and millions of children would continue to die unnecessarily every year (UNICEF, 2011; UN, 2011).

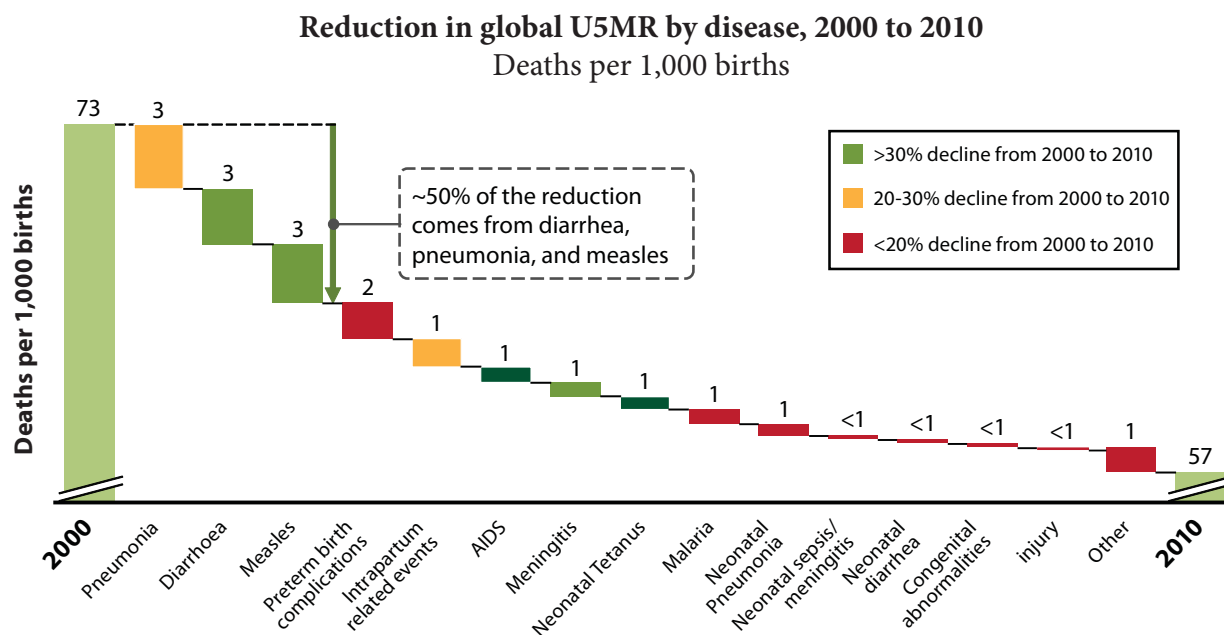
Many of the highest-burden countries, including Nigeria and Democratic Republic of the Congo, must at least triple their current rates of reduction to reach 20/1000 by 2035. Acceleration will not be easy, but it is possible. Many countries have achieved annual rates of decline of 5.2 percent or more in the past few years, including Ethiopia, Senegal, Rwanda, Kenya, Uganda, Ghana, Zambia, Mozambique and Tanzania (Demombynes et al., 2012; Ethiopia DHS, 2011).

Bending the curve

Business-as-usual will clearly not be enough to bend the curve to end preventable child deaths. Achieving this goal requires clear and strong commitment from leaders across government, civil society, and the private sector to prioritize child survival nationally and globally. It will also require them to scale up the proven, cost-effective solutions that address the underlying causes of child mortality. Finally, innovation has a critical role to play. One commentator has suggested that long-term trends in under-5 mortality are largely explained by expanding levels of maternal education and the introduction of new technologies and knowledge (Murray, NIH 2012). Investing in innovation will be critical to achieving ambitious child survival goals.

Every country must define its own targets, strategies, and objectives, including five-year benchmarks for monitoring progress toward the goal of ending preventable child deaths. Countries should refine their national plans, determine their own milestones to reach country targets of below 20/1000 by 2035, and trace a path toward equitable reduction in under-5 mortality at sub-national levels. These milestones can be reevaluated based on progress toward MDGs 4 and 5 and can help sharpen country child survival plans into the future. These milestones will help keep the focus on – and hold the global community accountable for – accelerating progress in the fight against child deaths.

Figure 3. Improving child survival has meant progress against a number of different causes of death.



1 Other includes other conditions for neonatal and non-neonatal causes of mortality; other conditions among children aged 1-59 months included congenital abnormalities, causes originated during the perinatal period, cancer, pertussis, severe malnutrition, pediatric TB and other specified causes.

Source: Liu et al. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000 (2012), *The Lancet*, Early Online Publication

ESTABLISHING A BASELINE: WHERE WE ARE TODAY

The global health community has witnessed substantial progress during the last 20 years in improving the chances that a child will survive to his or her 5th birthday. In 1990, 12 million children died every year before the age of 5. By 2010, that number had dropped to 7.6 million, a 35 percent reduction. Progress has been made against a number of causes of child mortality, including progress on improving nutrition and birth spacing. About half of the reduction between 2000 and 2010 (from 9.6 million to 7.6 million) can be attributed to improvements in combatting three life-threatening conditions: pneumonia, diarrhoea, and measles (Liu et al., 2012) (Figure 3).

This progress is the result of the unwavering commitment, focus, and hard work of many country and global actors, including government at all levels,

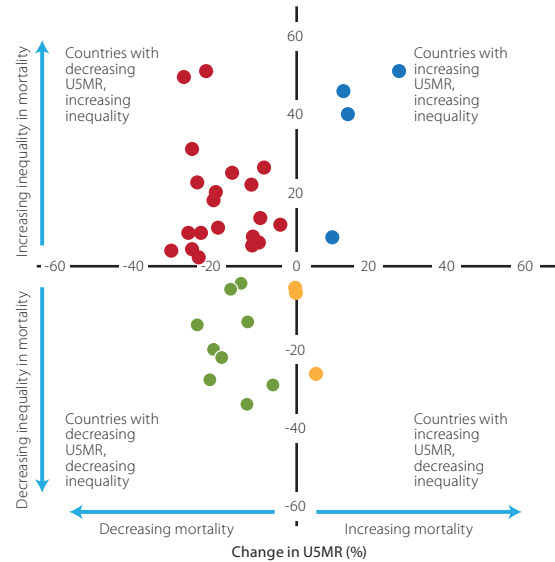
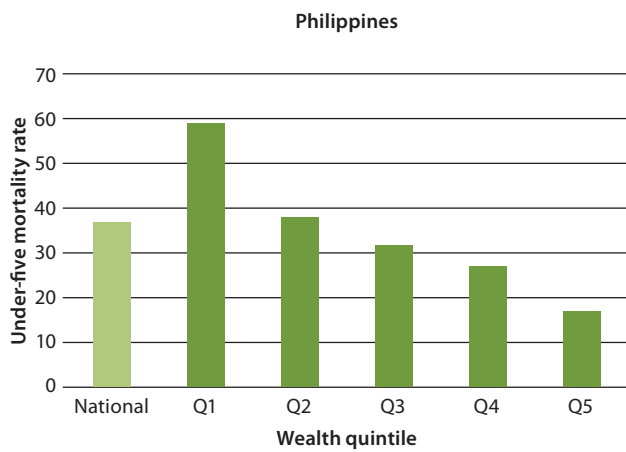
civil society, faith communities, community health workers, the private sector, bilateral and multilateral donors, and of course, families themselves. The collaboration demonstrated by the efforts of multiple global alliances and initiatives has also contributed to accelerating progress. The child survival community has rallied around evidence-based interventions to prevent and treat disease across the continuum of care – from pre-pregnancy, to childbirth and post-natal periods, to infancy and childhood.

These achievements are reflected in part in the important gains that have been made scaling up access to high-impact interventions. For example, mean coverage in developing regions of children 12–23 months old receiving at least one dose of measles vaccine increased by 16 percent between 2000 (70 percent) and 2008 (81 percent) (MDG Report, 2010). The mean coverage of women attended at least once during pregnancy by skilled health care personnel

Figure 4. Even where national indicators improve, inequality might still be a problem.

“In many countries in which the under-five mortality rate has declined, disparities in under-five mortality by household wealth quintile have increased or remained the same”.

UNICEF Progress for Children, 2010



National averages can mask critical disparities by wealth quintile, urban-rural residence, and gender
 “Success” means reaching 20/1000 or below in every segment of society

Sources: UNICEF Progress for Children 2010; Philippines DHS 2008

increased by 25 percent between 1990 (64 percent) and 2008 (80 percent) (MDG Report, 2010).

Progress has not been evenly distributed

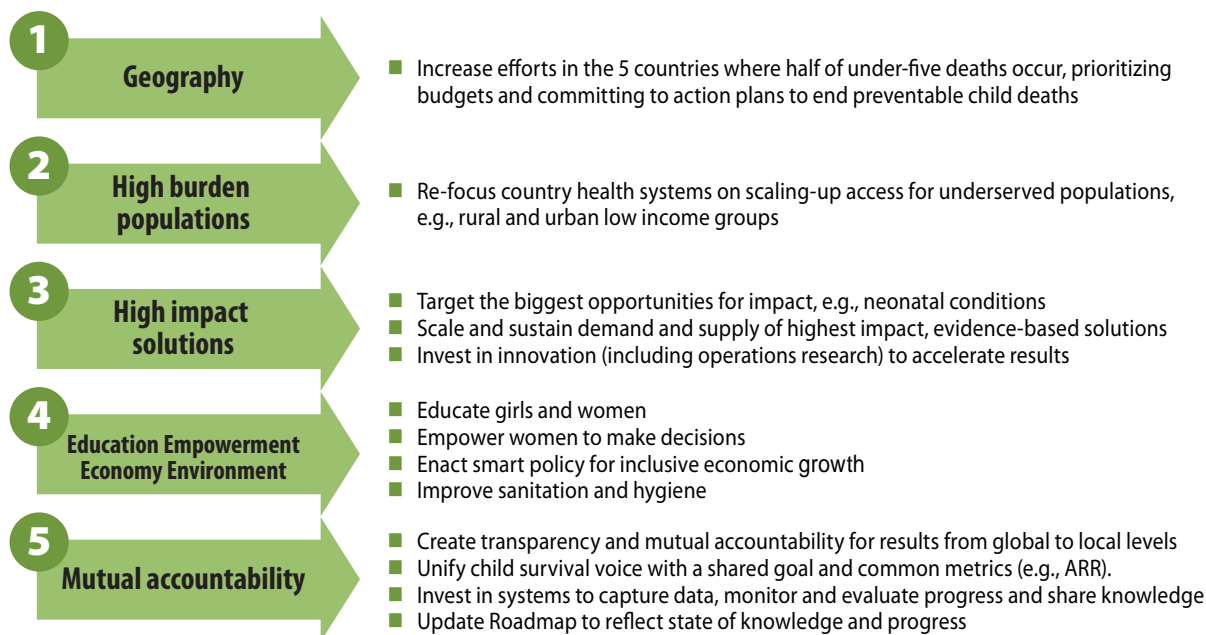
The mortality and coverage gains of the last 20 years, however, have been unequally distributed; results have been uneven across regions, countries, and population groups, and across specific causes of mortality.

The under-5 mortality rate (U5MR) also has varied by residence and population group. National averages can mask important sub-national differences. For example, across all regions and countries, including sub-national levels, the U5MR is higher among the poorest households (Figure 4). And while in the ag-

gregate, urban dwellers have better child mortality outcomes than rural populations, for the urban poor, the most rapidly growing subpopulation globally, mortality can be as high as for poor rural populations. Moreover, substantial disparities between rich and poor in coverage with high-impact interventions, such as DTP3 immunization, skilled birth attendance, antenatal care, satisfaction of family planning needs, and insecticide treated bednets for children have been well documented (Barros et al., 2012).

More evenly distributed gains across regions, countries, and population groups and targeting high-impact interventions to specific causes of mortality will require some strategic shifts to reduce child mortality. Today, new data insights, effective technologies, and country innovations make these shifts possible.

Figure 5. Ending preventable child deaths requires a new way of “doing business.” Evidence points to five strategic shifts that would accelerate progress globally and in countries.



HOW TO GET EVERY COUNTRY TO AT LEAST 20 BY 2035: FIVE STRATEGIC SHIFTS

Meeting MDGs 4 and 5 – and speeding up our progress to end preventable child deaths – requires a new way of doing business, focusing on five crucial shifts in action described below and summarized in Figure 5.

1. Geography

Twenty-four countries account for 80 percent of under-5 child deaths, and of these, five countries – India, Nigeria, Democratic Republic of the Congo, Pakistan, and Ethiopia – account for almost 50 percent of global under-5 mortality. The goal of ending preventable child deaths will be nearly impossible to attain without accelerated progress within each of these five countries. The 19 countries that account for an additional 30 percent of under-5 deaths are also important in driving global U5MR down. As with the five highest-burden countries, this next group of countries must also commit resources and receive support proportional to their under-5 mortality challenges.

High-burden countries can and do assume leadership of child survival efforts and draw on the expertise and support of a range of actors, including the private sector, civil society organizations, and faith-based organizations. These efforts can include setting goals and targets for child survival, targeting financing to child health, and developing explicit business plans for achieving success. The global community also needs to collaborate more closely with these countries to help them overcome the barriers to successful, sustainable child health programs.

2. Increasing efforts with high-burden populations

As described above, the child mortality burden can vary considerably within countries and can be quite high in pockets even when, on average, a nation is doing well. Countries should increasingly target their efforts to the highest burden areas at sub-national levels (e.g., rural and low-income populations and other marginalized groups). In Nigeria, for example, 33 percent of all child deaths occur in the poorest

quintile, while only 7 percent occur in the wealthiest quintile. Equity-based approaches can expand services and reduce disparities in access to essential services and in out-of-pocket expenditures. These approaches have the potential to achieve significant reductions in the U5MR among the most excluded populations.

Effectively increasing health outcomes for the poor requires enacting policies to expand health care coverage, as Nepal did in 2007 when the government legislated free health care. By scaling up integrated and community-based delivery platforms, health extension workers (Box 1) and other community-based health workers can deliver packages of essential health care services. Eliminating user fees, reducing transport costs, expanding outreach services, and upgrading facilities for maternal and newborn care can address chronic barriers to service utilization (UNICEF, 2010).

Finally, in order to monitor local progress, countries must improve national and sub-national data collection. Better data collection will help determine local priorities and adapt health interventions to local conditions and demands.

There are no standard solutions for adequately addressing the special needs of populations in rural and remote settings, especially when they have little or no political voice. Appropriate solutions need to be adapted to local conditions. Civil society including the faith-based community will continue to play a vital role in reaching underserved populations.

3. Applying cost-effective solutions to the most important causes of under-5 deaths

Countries should systematically identify as priorities the most important causes of under-5 deaths and the cost-effective, evidence-based interventions and delivery strategies that have the largest potential for sustained impact. Globally, five conditions – pneumonia, preterm birth complications, diarrhea,

Box 1. Ethiopia

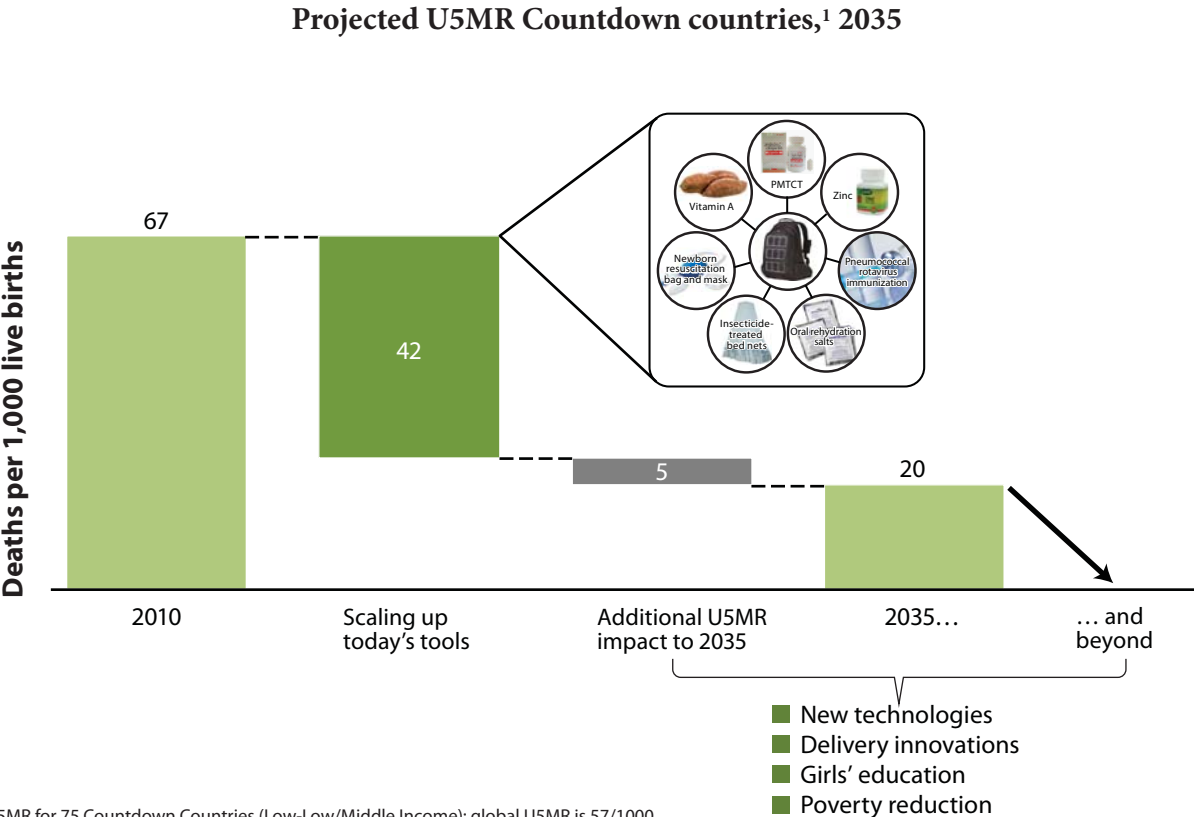
In 2004, Ethiopia launched its Health Extension Program (HEP), which was designed to deploy salaried health extension workers (HEW) to promote healthy behaviors at the household and village levels. HEWs provide health education and targeted preventive services in water and sanitation, child health, and family planning. Over time, the scope of the program has expanded to include treatment components, such as community case management of diarrhea, pneumonia, and malaria.

Expansion of the program has been swift. Since 2004, 35,000 health workers have been trained. Communities have built 15,000 health posts. The Government has embarked on a program to construct new health centers and primary hospitals and has accelerated training of key cadres of health workers, including health officers and midwives.

The HEP program has contributed to important gains in child health. The U5MR declined from 123 deaths/1000 live births in 2005 to 88/1000 live births in 2011, an average annual rate of decline of 5.4 percent. The percentage of children under-5 who are stunted was reduced by 14 percent during that same period. Furthermore, the percentage of married women (15–49 years of age) who use a modern method of contraception increased by 93 percent.

(Source: Government of Ethiopia, 2005, 2011; Interviews with USAID/Ethiopia)

Figure 6. Scaling and sustaining existing solutions will save millions of lives. There are effective, inexpensive interventions that help reach underserved rural and urban areas pulling other needed interventions in their wake.



¹ U5MR for 75 Countdown Countries (Low-Low/Middle Income); global U5MR is 57/1000

Source: Based on Lives Saved Tool modeling by Johns Hopkins Bloomberg School of Public Health 2012

intrapartum-related events, and malaria – represent more than 50 percent of the global burden of under-5 mortality. Scaling coverage of effective interventions that address the top causes in the highest-burden countries would mean potentially millions of child deaths averted every year. Scaling known, effective solutions will get countries most of the way to achieving their targets. More is possible through innovation, improvement in health systems and affecting the broader context (e.g., education, economic growth, and sanitation and hygiene) (Figure 6).

Yet, global attention to and investment in these causes is not commensurate with their share of the global disease burden. **Rwanda** (Box 2) systematically made high-burden diseases a national priority and has successfully demonstrated what it takes to accelerate a decline in child mortality.

Improving nutrition and family planning can also significantly decrease under-5 mortality. By giving mothers their best chance for a healthy childbirth, and newborns their best chance for a healthy start, millions of child deaths could be averted. For example, maintaining a three-year interval between birth and subsequent pregnancy would prevent approximately 1.8 million under-5 deaths annually (Rutstein, 2008). And, nutrition-related factors are responsible for approximately one-third of child deaths, representing an underlying cause of approximately 2.5 million child deaths a year (Save the Children, 2012). Tanzania has been making steady progress in vitamin A supplementation, scaling to over 90 percent coverage and with an impact on child survival (Box 3).

Countries will not achieve significant reductions in under-5 mortality rates without addressing **neonatal**

Box 2. Rwanda

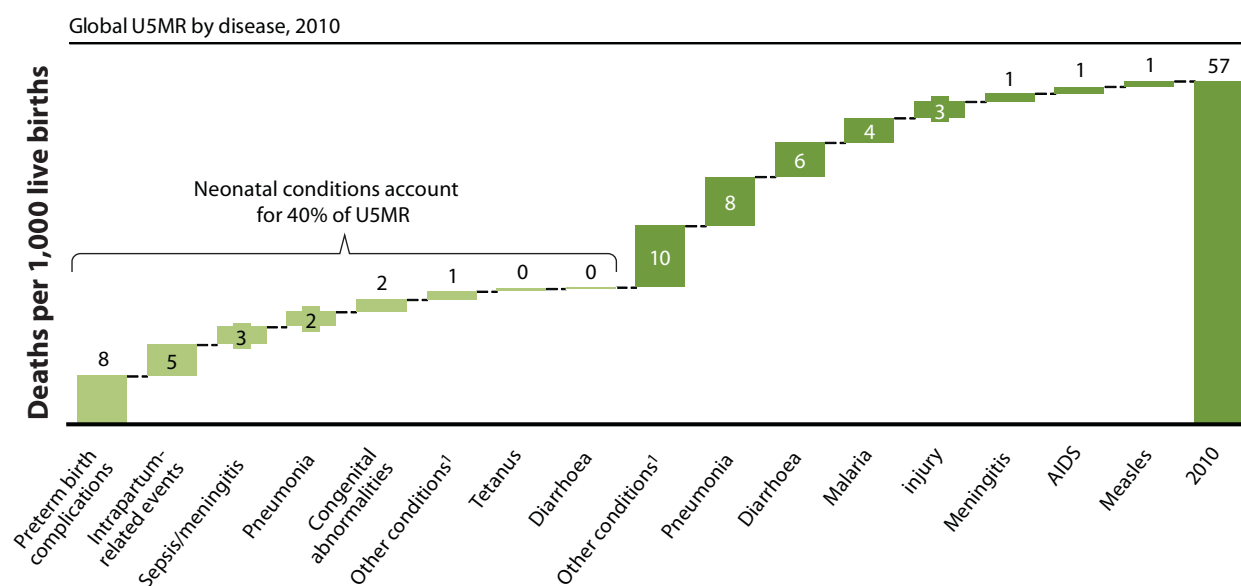
In 2001–2002, the Government of Rwanda made a commitment to use community health workers (CHWs) to address the top three causes of under-5 mortality in the country – malaria, pneumonia, and diarrhea. The government trained approximately 60,000 CHWs between 2001 and 2012 with the goal of having two CHWs responsible for every village.

In 2005, the government focused its efforts on malaria – the number one cause of under-5 mortality – and scaled up community-based delivery of artemisinin-based therapies and long-lasting insecticide-treated bednets. They also targeted indoor residual spraying in high prevalence areas. In 2009, the government took on pneumonia as its next priority. The government secured pneumococcal vaccine for national distribution and trained CHWs on rapid diagnostics to distinguish malaria from pneumonia, and on case-management of pneumonia with amoxicillin and zinc supplements. According to its most recent DHS, Rwanda has seen a significant reduction in acute respiratory illness from 17 percent in 2005 to 4 percent in 2010

In 2012, diarrhea and neonatal mortality were targeted as the next priorities. Funding for distribution of rotavirus vaccine has been negotiated. Through these and other high-impact initiatives, the U5MR dropped from 150/1000 in 2000 to 76/1000 in 2010.

Source: UN Data, Interviews with USAID, JHPIEGO, Rwanda MOH

Figure 7. Neonatal conditions, pneumonia, diarrhea, and malaria account for more than 75 percent of under-5 mortality.



¹ Other includes other conditions for neonatal and non-neonatal causes of mortality; other conditions among children aged 1-59 months included congenital abnormalities, causes originated during the perinatal period, cancer, pertussis, severe malnutrition, pediatric TB and other specified causes.

Source: Liu et al. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000 (2012), The Lancet, Early Online Publication

Box 3. Vitamin A Supplementation

Vitamin A supplementation (VAS) is among the most cost-effective child survival interventions. It has been proven to reduce child mortality by as much as 23 percent.

Tanzania's early efforts on VAS have contributed to significant declines in child mortality (Government of Tanzania, 2010; USAID, 2012; UNICEF, 1993). In 1997, Tanzania integrated VAS into its immunization program to expand national coverage to children below 2 years of age. In 2005, Tanzania began intensifying efforts to make twice-yearly VAS a priority for all children ages 6–59 months. Recognizing the important impact of this program, district authorities across Tanzania now routinely include VAS within their annual plans and budgets. The coverage rate for VAS is currently more than 90 percent.

Tanzania recently launched a cross-sector nutrition strategy to accelerate what has been slow progress on under-nutrition: the percentage of stunted children under-5 has remained relatively constant over recent years (44 percent in 2004/2005, 42 percent in 2009/2010). Acknowledging the high burden of stunting in Tanzania, the country's leaders have elevated nutrition as a top priority for economic growth and development. The national vision is to reduce the child stunting rate to less than 22 percent by 2015.

conditions, which account for approximately 40 percent of child deaths globally (Liu et al., 2012)(Figure 7). Yet, improvements in neonatal survival continue to persist even amidst declines in child deaths. As countries reduce child mortality overall, neonatal mortality often constitutes a growing percentage of the remaining burden.

Significant reductions in neonatal deaths require interventions that directly address the neonatal period as well as maternal health interventions that protect both the mother and child: expansion of facility-based care, better use of skilled frontline health care workers and regular access to life-saving commodities.

Immediate gains can be made by improving access to other community-based services and overcoming barriers to the use of such services. Increasing use of skilled birth attendants, for example, may require providing incentives to mothers and other efforts to overcome cultural barriers to delivering in a facility.

Egypt significantly reduced neonatal mortality by

expanding services addressing neonatal and maternal health (Box 4).

Access to and effective use of commodities where and when they are needed is a critical component of cost-effective interventions. Innovation can have a significant impact on our ability to manage supply chain (e.g., Tanzania significantly reduced stock-outs of critical commodities by introducing an SMS-based reporting system) (Box 5). The U.N. Commission on Life-Saving Commodities for Women and Children is finalizing a set of recommendations to strengthen the marketing, distribution and monitoring of commodities. These recommendations will address improved markets, improved quality, improved national delivery, and improved integration of the private sector and consumer needs, all of which have the potential for considerable impact on child survival.

Implicit in the foregoing is that scaling up and sustaining high-impact interventions depends on strengthening both the demand for, and the supply of, health care. It is becoming clear that the global community

Box 4. Egypt

A 1992 survey on maternal mortality focused national attention on the need to improve maternal, neonatal, and child health services (MNCH). In response to the survey, the country launched two programs to scale up MNCH services: Safe Motherhood (1992) and Healthy Mother Healthy Child (1993). These programs contributed to a halving of the maternal mortality ratio between 1992 and 2000. Furthermore, the under-5 and neonatal mortality ratios steadily declined at an annual average rate of 7.0 percent and 5.5 percent, respectively, between 1990 and 2010.

Source: WB-PMNCH analysis 2012; UN Data

should increase attention to the demand side to ensure proper uptake of services that are offered.

4. Addressing the broader context: education, empowerment, economy, and environment

In addition to the focus on the health sector and medical interventions, greater investment is also needed in policies and programs that have an impact on child survival more broadly and address the underlying causes of child mortality. These policies and programs include education, infrastructure development, water supply, sanitation, and income generation.

Progress in the highest-burden countries on non-health sectors that have an impact on child survival has been uneven, despite the significant potential of interventions like girls' education (Figure 8). Accelerated efforts in these sectors should be incorporated into national and global child survival priorities.

5. Mutual accountability for ending preventable child deaths

*Commitment to child Survival:
a promise renewed*

To advance Every Woman Every Child, UNICEF and other U.N. agencies invite partners from the public, private, and civil society sectors, as well as relevant global alliances, to join **Committing to Child Survival: A Promise Renewed** by pledging to pursue this clear and compelling goal: ending preventable child deaths.

Each of us has an important role to play in A Promise Renewed. Governments will lead the effort by sharpening their national action plans, with costed strategies for maternal and child survival, and by setting and monitoring five-year milestones. Development partners can support the national targets by pledging to align their support with government-led action plans and priorities; private sector partners can spur innovation and help identify new resources for child survival; and, through action and advocacy, civil society and faith leaders can support the communities and families whose decisions profoundly influence prospects for maternal and child survival. What is critical in each case is that stakeholders make child survival a regular part of the way they plan, budget, and conduct business.

This is already happening. Governments are sharpening national plans to accelerate progress toward ending preventable child deaths, setting national targets, strengthening country scorecards with sub-national data to monitor progress, identifying and promoting partnerships with country stakeholders and allocating and aligning funding and technical support using criteria tied to objective data on highest burdens – geographies, causes, and populations. More broadly, governments are also using their voices to elevate child survival in regional and global forums and incorporate it into strategic dialogues with leaders of other countries.

Global partners, nongovernmental organizations, and the private sector will similarly undertake promoting

Box 5. Using Mobile Phones to Improve Supply Chain Integrity

In many countries, stock-outs of key commodities, particularly in rural health facilities, can be a major impediment to combating high-burden diseases. The SMS for Life Initiative is an example of an innovative approach to eliminate stock-outs of anti-malarial drugs. The program uses mobile phones, SMS messages and electronic mapping to track weekly stock levels of malaria medicines at public health facilities. Weekly stock requests are sent by SMS to a health care worker at each facility. Stock messages are then returned at no cost to the health care worker. District managers access data on stock levels via a secure website.

The preliminary impact in Tanzania has been promising. Stock-outs were reduced from 79 percent to less than 26 percent in three districts. Approximately 5,000 facilities were trained and are tracking inventory on a weekly basis. Based on this success, additional medicines, such as those for TB, are now being tracked. The program is expanding to other countries, including Kenya and Democratic Republic of the Congo (Barrington et al., 2010).

the goal of ending preventable child deaths in their work. Some have already done so. For example, the Global Fund to Fight AIDS, Tuberculosis and Malaria will frame its grants as contributing to broader global goals, including ending preventable child deaths, requesting that countries identify how the funds will contribute to child survival, and the World Bank is working on including child survival indicators into World Bank processes (CAS, PRSP, corporate score-cards) and elevating its place on the Bank's research agenda. More can, and will, be done.

To meet our renewed commitment to child survival, UNICEF will establish a small secretariat to support the activities of A Promise Renewed and help focus collective efforts on three fronts:

1. Evidence-based country plans

At the national level, participating governments will lead the effort to sharpen country action plans for child survival, with support from partners. To track and hasten declines in child mortality, governments and partners will identify five-year milestones for maternal, newborn and child survival, based on a detailed analysis of the nature, distribution and social determinants (particularly female education and gender

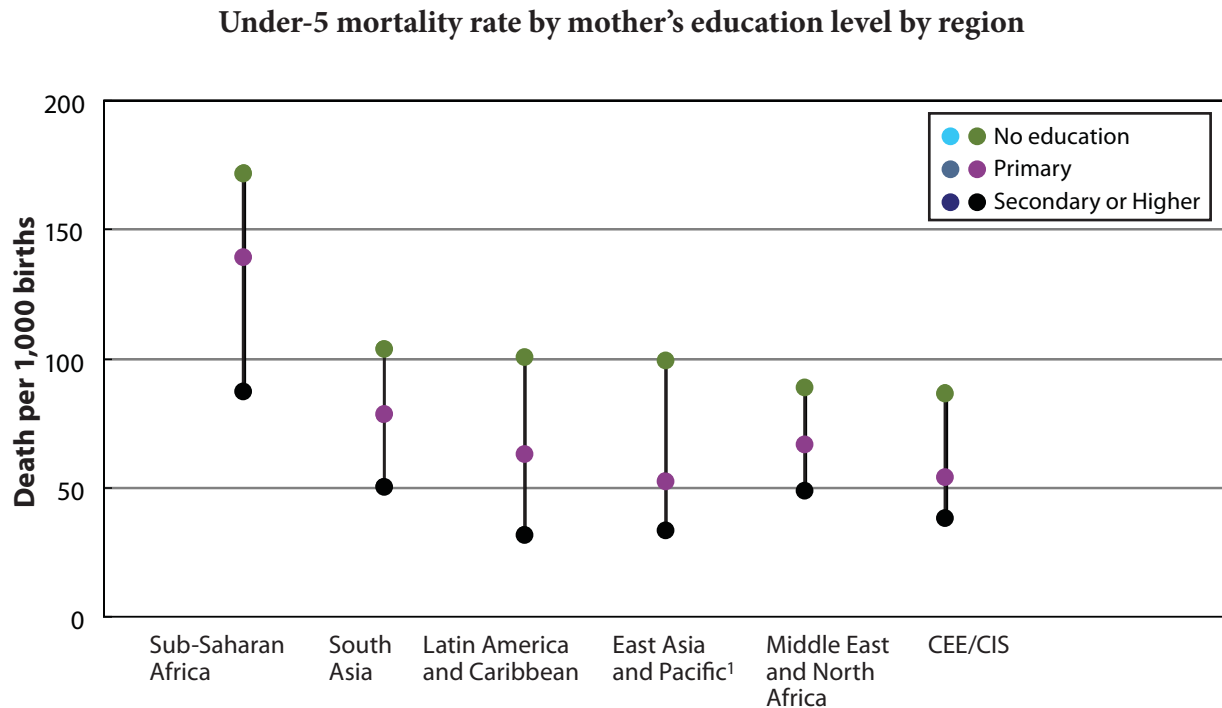
discrimination) of maternal and child mortality. The analysis will help governments better understand how to strengthen the efficiency and effectiveness of resource allocations, as part of a broader strategy to target national and international resources to those in greatest need.

The evidence-based country plans will be supported through the coordinated efforts of existing MNCH initiatives, such as Born Too Soon, the U.N. Commission on Life-Saving Commodities for Women and Children, Women Deliver, Global Action Plan for Pneumonia and Diarrhea, and SUN, among others. Emphasis will be placed on national priorities and country ownership. As governments cost and identify domestic financing for child survival strategies, development partners will help mobilize and direct resources to fill the financing gaps.

2. Transparency and mutual accountability

Governments and partners will work together to report progress and to promote accountability for the global commitments made on behalf of children. Using a standardized monitoring template, UNICEF and partners will collect and disseminate data on each country's progress. Based on the indicators

Figure 8. Disparities in education also correlate with disparities in death rates in all regions studied.



Inter-sectoral coordination will be required to address girls' education impacting child survival

¹ Excludes China

Source: UNICEF, Progress for Children: Achieving the MDGs with Equity, 2010

developed by the United Nations Commission on Information and Accountability for Women's and Children's Health, the global template is designed to be adapted by countries to address their own priorities. Each year, UNICEF and partners will release global progress reports to stimulate public dialogue and sustain the political commitment to child survival.

3. Global communication and social mobilization

Governments and partners will mobilize broad-based social and political support for the goal of ending preventable child deaths. As part of this effort, the search for small-scale innovations that demonstrate strong potential for large-scale results will be intensified. Once identified, local innovations will be tested,

made public, and taken to scale. By harnessing the power of mobile technology, civil society and the private sector can encourage private citizens, especially women and young people, to participate in the search for innovative approaches to maternal and child survival. UNICEF will host a small secretariat to support the efforts undertaken in support of A Promise Renewed.

Through communication and other forms of outreach, governments and partners will encourage broad-based social action in support of the goal of ending preventable child deaths. Civil society partners will mobilize policy makers and other actors to direct investments toward those in greatest need – communities with the highest rates of child and maternal mortality. At the same time, governments

and partners from the private sector and civil society will intensify the search for small-scale innovations that demonstrate potential for large-scale results. By harnessing the power of mobile technology, the private sector and civil society can encourage private citizens, especially women and youth, to participate in the search for innovative solutions to maternal and child survival. Once found, local innovations can be tested, publicized, and taken to scale.

REACHING 2015 AND BEYOND

Building on the momentum of the activities that will take place between June 2012 and September 2013, the partners of A Promise Renewed will periodically convene regional and global forums to assess progress, celebrate successes, and refine strategies for accelerating progress to 2015. In September of each year, a child mortality report will be issued under the banner of A Promise Renewed, with country profiles that track progress at the national and sub-national levels. Governments will be encouraged to share lessons learned and to identify high-impact strategies, which will be posted on the website of A Promise Renewed and showcased at relevant meetings and events. In preparation for 2015, we will bring together stakeholders to review and identify strategies to maintain the momentum and establish the processes necessary to monitor progress effectively from 2015 to 2035.

By pledging to work together to end preventable child deaths, the partners of A Promise Renewed are uniting in a common cause that every generation in history has instinctively embraced: doing our best so that children may survive and thrive.

References

- Ozawa S, et al. During the “decade of vaccines,” the lives of 6.4 million children valued at \$231 billion could be saved. *Health Affairs*. June 2011; Volume 30, Issue 6
- Demombynes G, et al. What Has Driven the Decline of Infant Mortality in Kenya? *World Bank*. May 2012
- Liu L, et al. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000. *Lancet*. May 2012
- UN Millennium Development Goals Report 2010 <http://www.un.org/millenniumgoals/reports.shtml>
- Borros A, et al. Equity in maternal, newborn, and child health interventions in Countdown to 2015: a retrospective review of survey data from 54 countries. *Lancet*. 31 March–6 April 2012, Pages 1225–1233
- Lim SS, et al. A conditional cash transfer programme to increase births in health facilities: an impact evaluation. *Lancet*. Jun 5 2011;375(9730):2009–2023.
- Black R, et al. The Lancet’s Series on Maternal and Child Undernutrition Executive Summary. *Lancet*. 2008 <http://www-tc.iaea.org/tcweb/abouttc/tcseminar/Sem6-ExeSum.pdf>
- Black R. Time to Tackle Undernutrition. *Lancet*, Volume 371, Issue 9608, Page 197, 19 January 2008
- The Millennium Development Goals Report 2011 [http://www.un.org/millenniumgoals/pdf/\(2011_E\)%20MDG%20Report%202011_Book%20LR.pdf](http://www.un.org/millenniumgoals/pdf/(2011_E)%20MDG%20Report%202011_Book%20LR.pdf)
- USAID 2012: Bangladesh DHS Preliminary Results <http://www.measuredhs.com/pubs/pdf/PR15/PR15.pdf>
- World Health Report 2005 Make Every Mother and Child Count http://www.who.int/whr/2005/whr2005_en.pdf
- Barrington J, et al. SMS for Life: a pilot project to improve anti-malarial drug supply management in rural Tanzania using standard technology. *Malaria Journal* 2010, 9:298
- Jones, et al. How many child deaths can we prevent this year? (2003) *The Lancet*; UNICEF State of the World’s Children 2008;
- UNICEF, Required Acceleration for Child Mortality Reduction beyond 2015, 2012
- Save the Children 2012, “Nutrition in the First 1,000 Days” and “A Life Free From Hunger”; Black et al Maternal and child under-nutrition: global and regional exposures and health consequences (2008), *The Lancet*; Rutstein, 2008; Baqui and Williams, 2008; Conde-Agudelo, 2000-2005; DaVanzo 2007; Report of a WHO Technical Consultation on Birth Spacing, Geneva, Switzerland, 13-15 June, 2005; USAID analysis; team analysis; Rutstein 2008
- UNICEF, Child Info, Monitoring the Situation of Children and Women, “Progress,” January 2012, based on UNICEF global databases 2011, from Multiple Indicator Cluster Surveys (MICS), Demographic Health Surveys (DHS) and other national surveys.
- UNICEF: Progress for Children: Achieving the MDGs with Equity, 2010
- Tanzania Demographic Health Survey, 2010; USAID- Tanzania Nutrition Profile 2012; Nutrition Policy Discussion Paper No. 13. Geneva: UN, 1993. UNICEF, State of the World’s Children accessed from <http://www.indexmundi.com><http://www.indexmundi.com>
- Rutstein S. Further Evidence of the Effects of Preceding Birth Intervals on Neonatal, Infant, and Under-Five-Years Mortality and Nutritional Status in Developing Countries. DHS Working Paper 41. September 2008.
- Murray, C. Presentation at National Institutes of Health, May 2012.

CHILD SURVIVAL
CALL to ACTION

Ending Preventable Child Deaths

Global Roadmap

Version 1
June 14, 2012

A close-up photograph of a woman wearing a yellow headscarf with white polka dots, smiling gently as she holds a baby wrapped in a white blanket. The baby is wearing a red and gold patterned headscarf. The background is softly blurred, suggesting an outdoor setting.

CHILD SURVIVAL
CALL to ACTION

Ending preventable child deaths

Global roadmap for neonatal, child and maternal survival

June 11, 2012



1 Executive summary

2 Vision for 2035

3 Where we are today

4 Strategic shifts to accelerate progress

5 Sustaining commitment

6 Case studies

What is the Global Roadmap for Child Survival?

The Global Roadmap ...

- ✓ A synthesis of the most current data and findings on child survival
 - Creates a baseline for where we are in our child survival work
 - Acknowledgement of the progress the global community has made in child survival
- ✓ Is part of a call to action, so that we can do more so fewer children under five die
 - Various visions on what “better” looks like
 - The outline of what a child survival “movement” would find useful
- ✓ Highlights the importance of the continuum of care and the tight linkage between maternal and newborn health
- ✓ A set of tools and resources that countries will find useful in sharpening their child survival strategies
 - Includes examples of where programs have helped accelerate change
- ✓ Will help us change how we do business, to make our efforts more effective and impactful
- ✓ A starting point for a global dialogue involving governments, CSOs, private sector and others
 - An input into the CS community dialogue about post-2015 goals, actions and target dates
 - Would look for an official statement of the community’s position in a year

Ending Preventable Child Deaths – A Vision We Share

It's the right thing to do – every child deserves a fifth birthday

It is within our reach

- 7.6 million children die each year before their fifth birthday
- Nearly all these deaths are preventable with known cost-effective solutions

It makes economic sense

- Improving child survival brings a demographic dividend through fertility declines, reduced mortality, and increased economic productivity
- Reduction in child mortality can result in billions of dollars in direct economic savings –life-saving vaccines alone could save 6.4 million lives and \$231 billion in productivity by 2020

It is an indicator of good governance – child survival reflects national policy promoting investment in **equitable social and economic progress** e.g., women's empowerment and education, availability of safe drinking water and basic sanitation, safety of the child's environment



Source: Jones, et al. How many child deaths can we prevent this year? (2003) *The Lancet*; UNICEF State of the World's Children 2008; Ozawa *et al.* During the decade of vaccines, the lives of 6.4 million children valued at \$231B could be saved (2011) *Health Affairs*, 30, 1010-1020 ; Convention on the Rights of the Child; The UN Inter-agency Group for Child Mortality Estimation, Levels and Trends in Child Mortality: Report 2011, 2011

Critical to success in bending the curve on under-five mortality will be country leadership and political commitment

Country action...

- Countries refine their own national plans
- Countries determine their own targets and milestones
- Each country to choose its own path e.g., equitable reduction in U5MR throughout country, coverage targets of specific interventions, policy and technology innovations
- Roadmap, templates and tools available to assist in planning

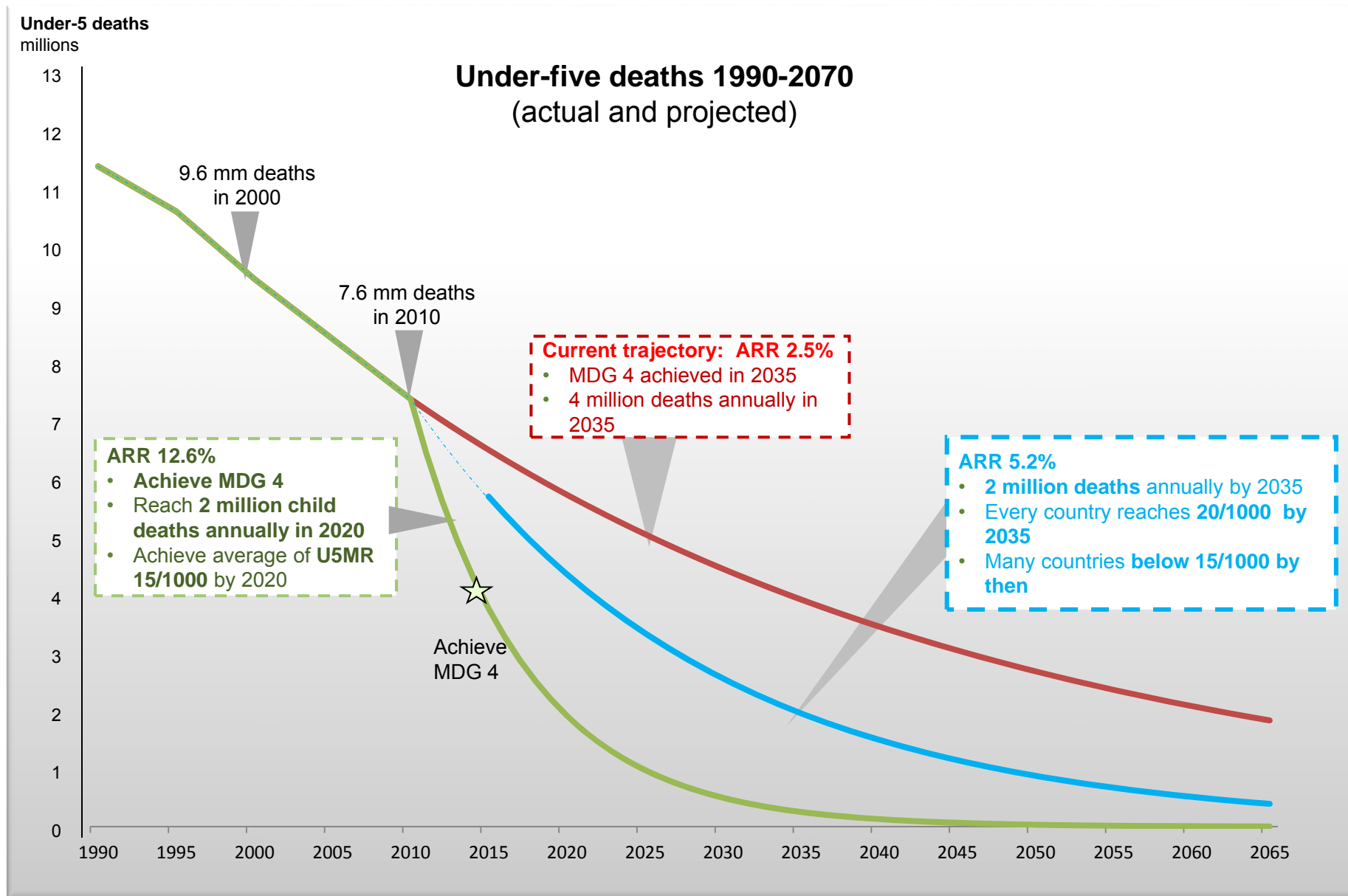
...rolls up to global targets...

- The aggregate of country planning and implementation rolls up to the global targets
- Five year interim targets to track progress
- Milestones would be re-evaluated based on sharpened national child survival plans for 2020

...creates a fact-base and starting point for post-2015 discussions

- Child survival prioritized
- Greater shared knowledge of countries' starting points
- Planning process underway in some countries
- Greater resource alignment

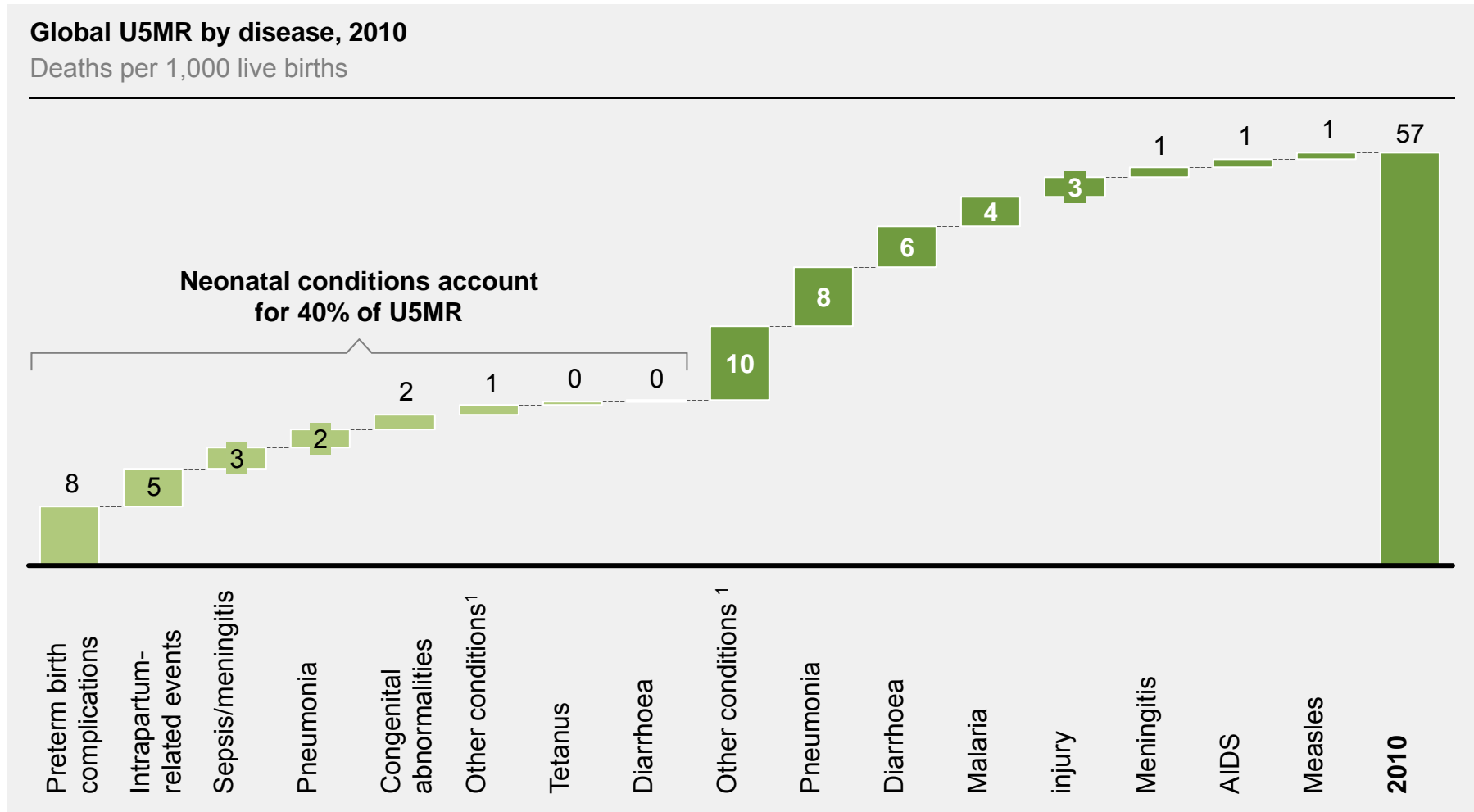
Accelerating progress on child survival – what can the world achieve if countries increase their annual rate of reduction?



Source: UNICEF State of the World's Children 2012; The UN Inter-agency Group for Child Mortality Estimation, Levels and Trends in Child Mortality: Report 2011, 2011; Team analysis from 2035 onward based on straight-line ARR reduction from UNICEF numbers 1990-2035

CHILD SURVIVAL
CALL to ACTION

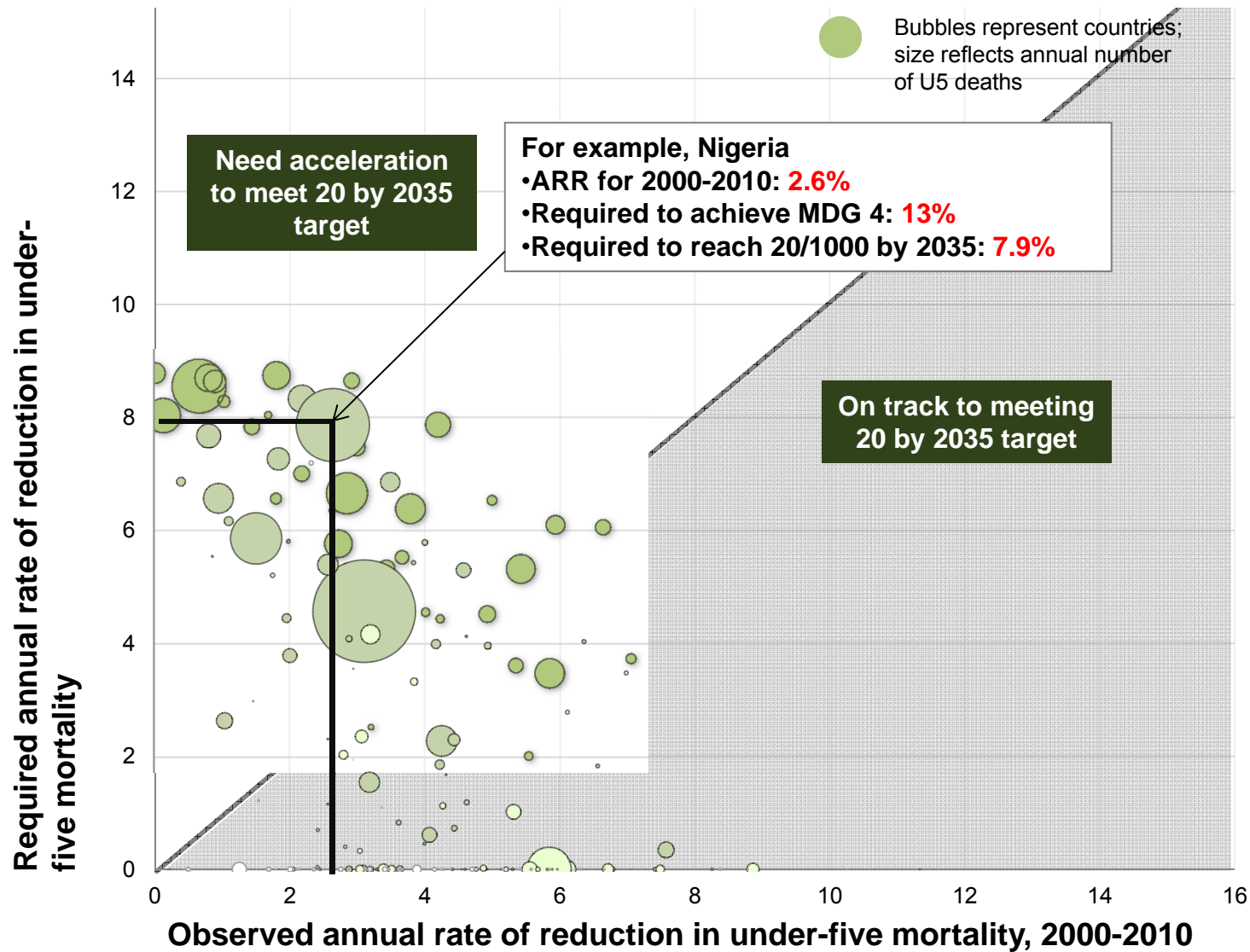
Neonatal conditions, pneumonia, diarrhea, and malaria account for over 75% of under-five mortality.



¹ Other includes other conditions for neonatal and non-neonatal causes of mortality; other conditions among children aged 1-59 months included congenital abnormalities, causes originated during the perinatal period, cancer, pertussis, severe malnutrition, pediatric TB and other specified causes.

Source: Liu et al. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000 (2012), The Lancet, Early Online Publication

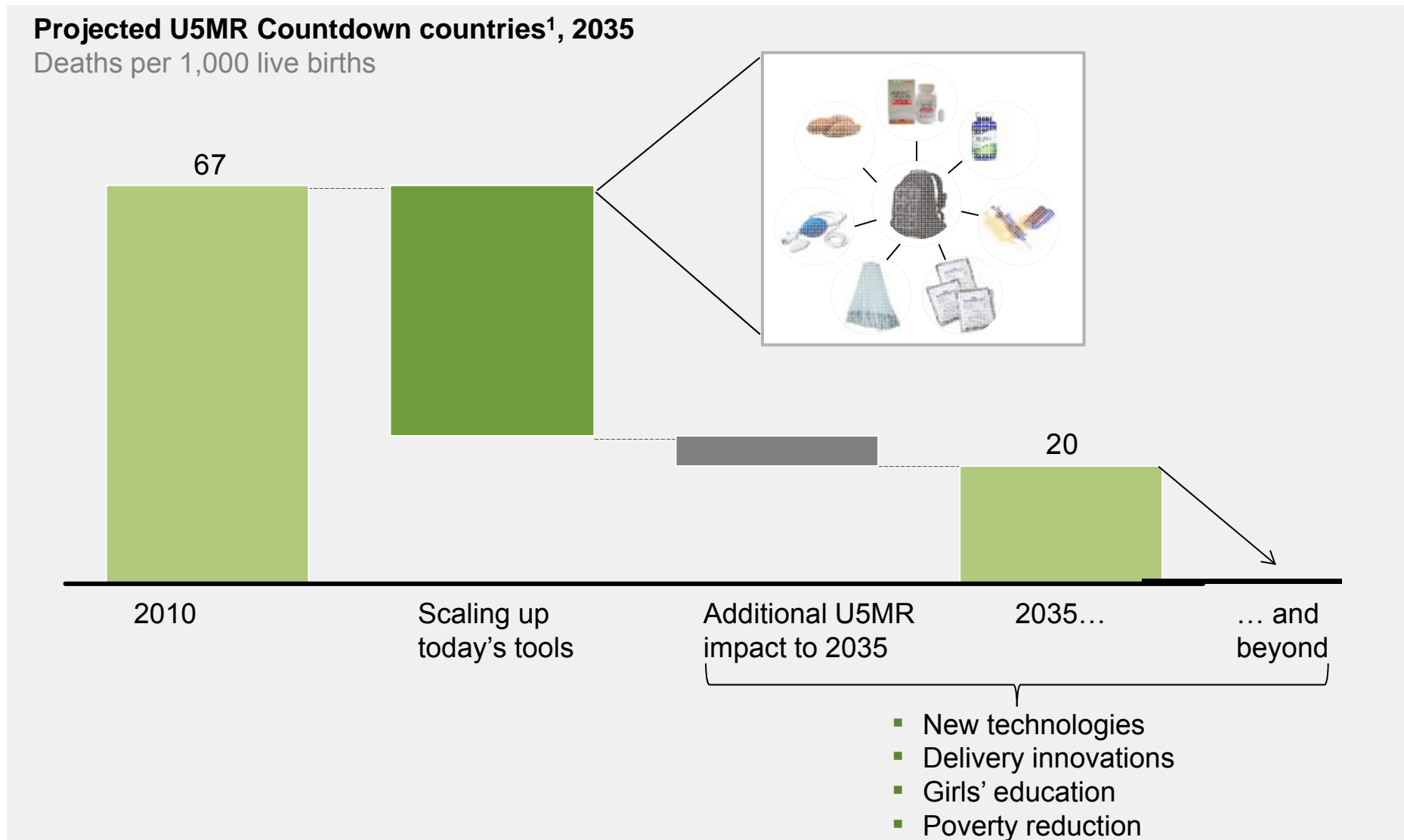
Many countries need to dramatically accelerate progress, reviewing their own national plans in light of new data and learning – example illustrates what is required for every country to reach U5MR of 20/1000 or below by 2035



Source: T Wardlaw, D You UNICEF

Many countries can accelerate progress to goals by sharpening national plans

Scaling and sustaining existing solutions will save millions of lives – there are effective, inexpensive interventions that help reach underserved rural and urban areas pulling other needed interventions in their wake



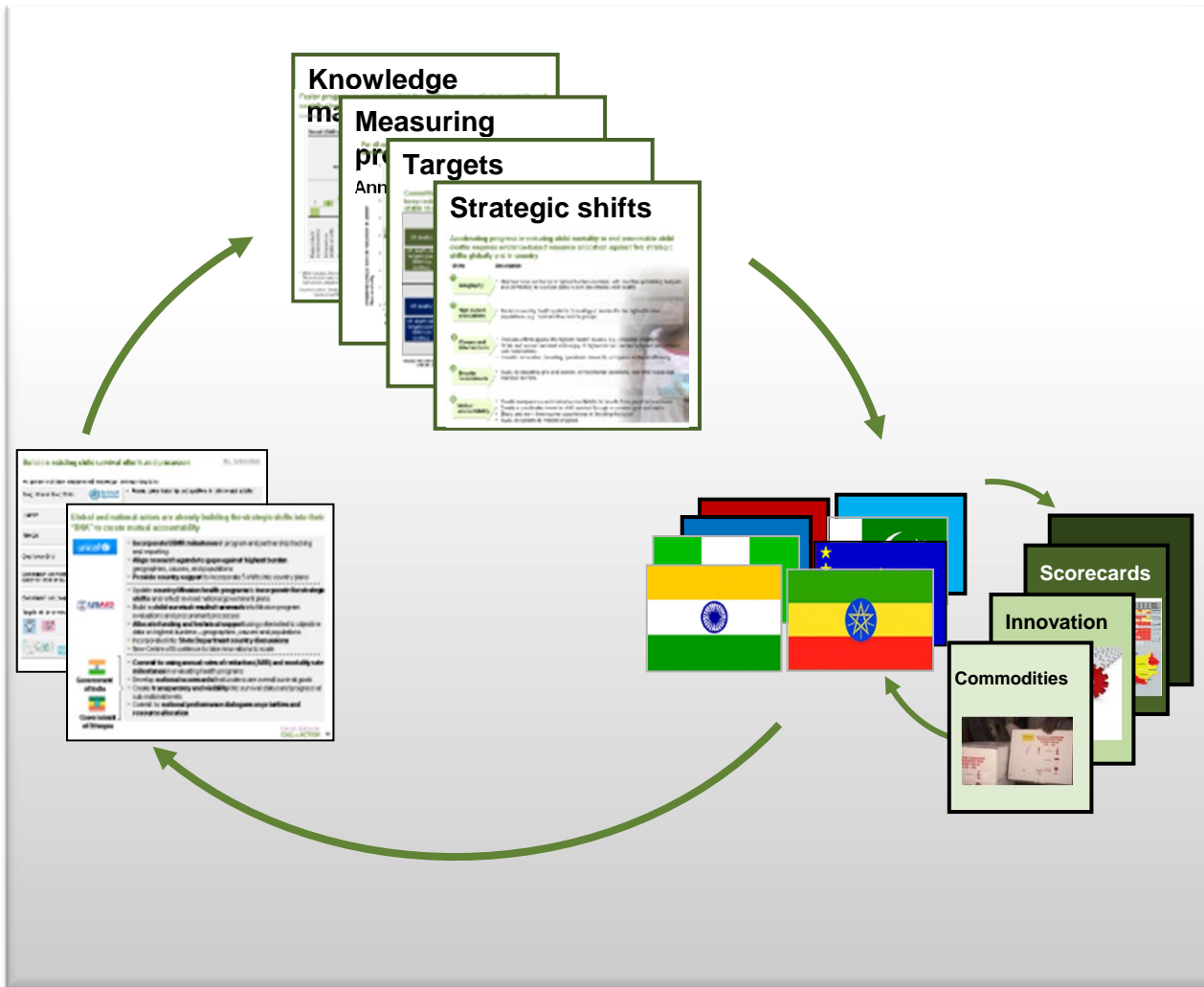
¹ U5MR for 75 Countdown Countries (Low-Low/Middle Income); global U5MR is 57/1000

Source: Based on Lives Saved Tool modeling by Johns Hopkins Bloomberg School of Public Health 2012

Ending preventable child deaths requires a new way of “doing business”. Evidence points to five strategic shifts that would accelerate progress in countries and globally

- 1 Geography**
 - Increase efforts in the 5 countries where half of under-five deaths occur, prioritizing budgets and committing to action plans to end preventable child deaths
- 2 High burden populations**
 - Re-focus country health systems on scaling-up access for underserved populations, e.g., rural and urban low income groups
- 3 High impact solutions**
 - Target the biggest opportunities for impact, e.g., neonatal conditions
 - Scale and sustain demand and supply of highest impact, evidence-based solutions
 - Invest in innovation (including operations research) to accelerate results
- 4 Education
Empowerment
Economy
Environment**
 - Educate girls and women
 - Empower women to make decisions
 - Enact smart policy for inclusive economic growth
 - Environmental factors addressed e.g., sanitation and hygiene
- 5 Mutual accountability**
 - Create transparency and mutual accountability for results from global to local levels
 - Unify child survival voice with a shared goal and common metrics (e.g., ARR).
 - Invest in systems to capture data, monitor and evaluate progress and share knowledge
 - Update Roadmap to reflect state of knowledge and progress

A Global Roadmap will capture the specific goals, state of knowledge and progress of child survival, as it evolves through the leadership of countries and other stakeholders



- ✓ Country plans optimized using best available data and knowledge
- ✓ Existing organizations regularly pull together country experiences and include in the global roadmap
- ✓ Roadmap continuously updated to provide
 - ☐ Newest data on global and country progress
 - ☐ More insight into what works, what doesn't and why

5 A Promise Renewed – a broad vision for sustaining the commitment to end preventable child deaths

A Promise Renewed

Working together to accelerate action on maternal, newborn and child survival by targeting investments in effective, life-saving interventions for children

National governments lead the effort by sharpening country action plans, with costed strategies for maternal and child survival, and identify five-year milestones for progress at the national and sub-national levels

Development partners pledge to align their support with government-led action plans and priorities

Private sector partners spur innovation and help identify new resources for child survival

Civil society promotes accountability and, through advocacy and action, supports the communities and families whose decisions influence prospects for maternal and child survival



1

Executive summary

2

Vision for 2035

3

Where we are today

4

Strategic shifts to accelerate progress

5

Sustaining commitment

6

Case studies

Why is now the right time for a new goal in child survival?



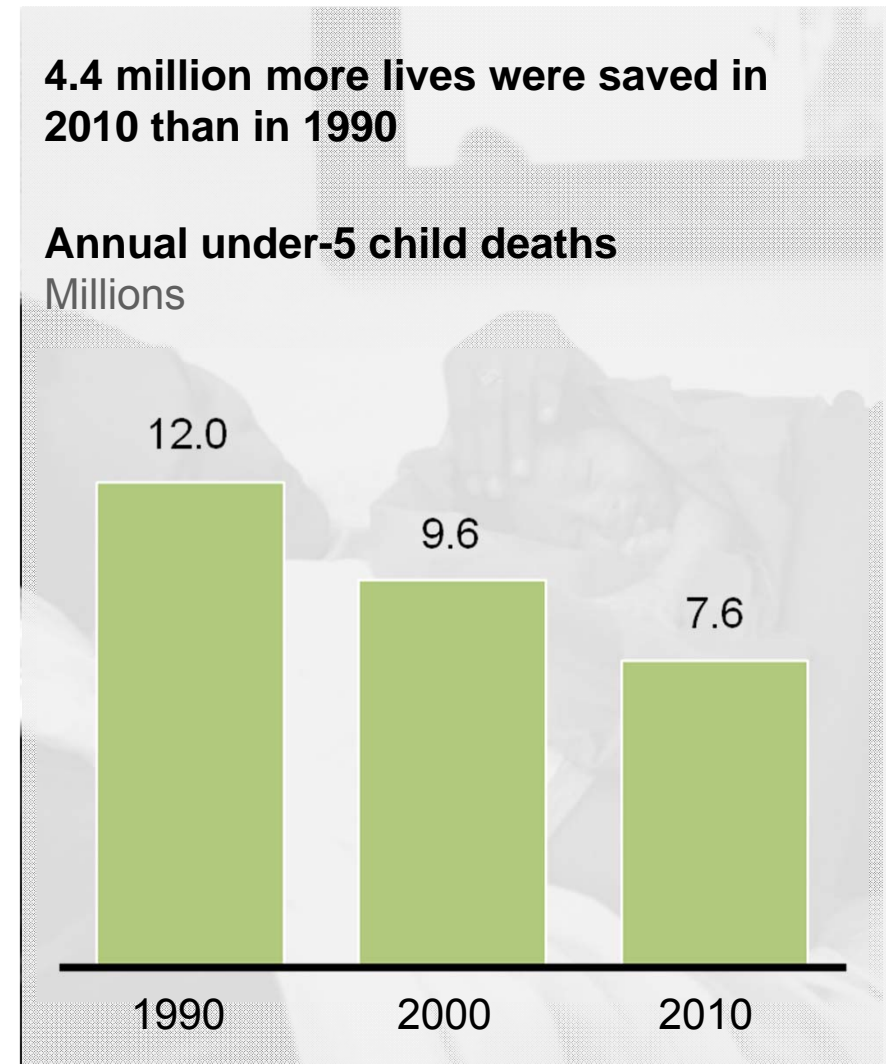
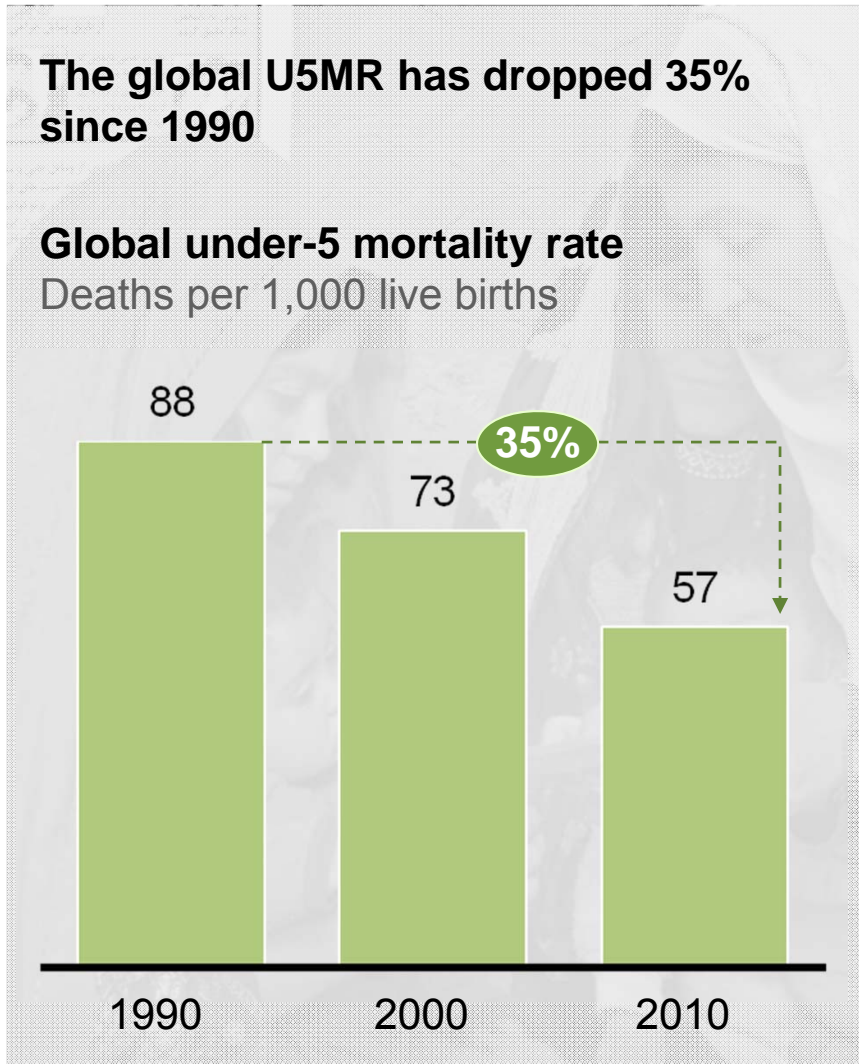
Significant progress against MDG4 but we're nearing 2015 – opportunity to accelerate progress towards MDG4 and define a new global agenda for child survival beyond 2015

Despite significant progress, challenges remain – variable progress requires targeted strategies to reduce child mortality

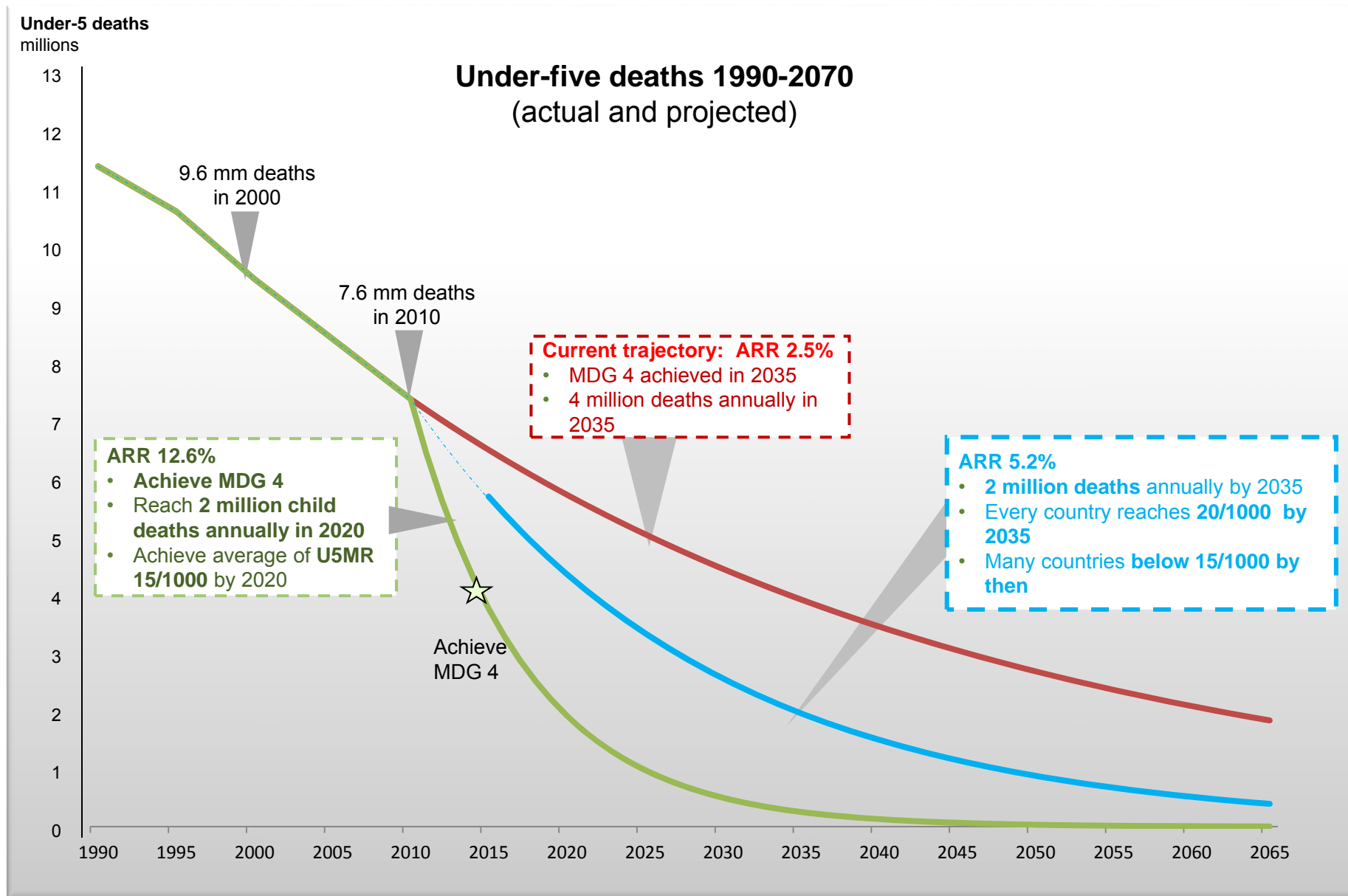
New data insights, effective technologies and country innovations enable **strategic shifts** towards ending preventable child deaths by an increased **focus on priority countries, diseases, populations and proven interventions** that will have the most impact

Accelerated action now based on data and science can inform planning and investment and save millions of lives a year

Substantial progress has been made to date: millions more children are making it to their fifth birthday



Accelerating progress on child survival – what can the world achieve if countries increase their annual rate of reduction?

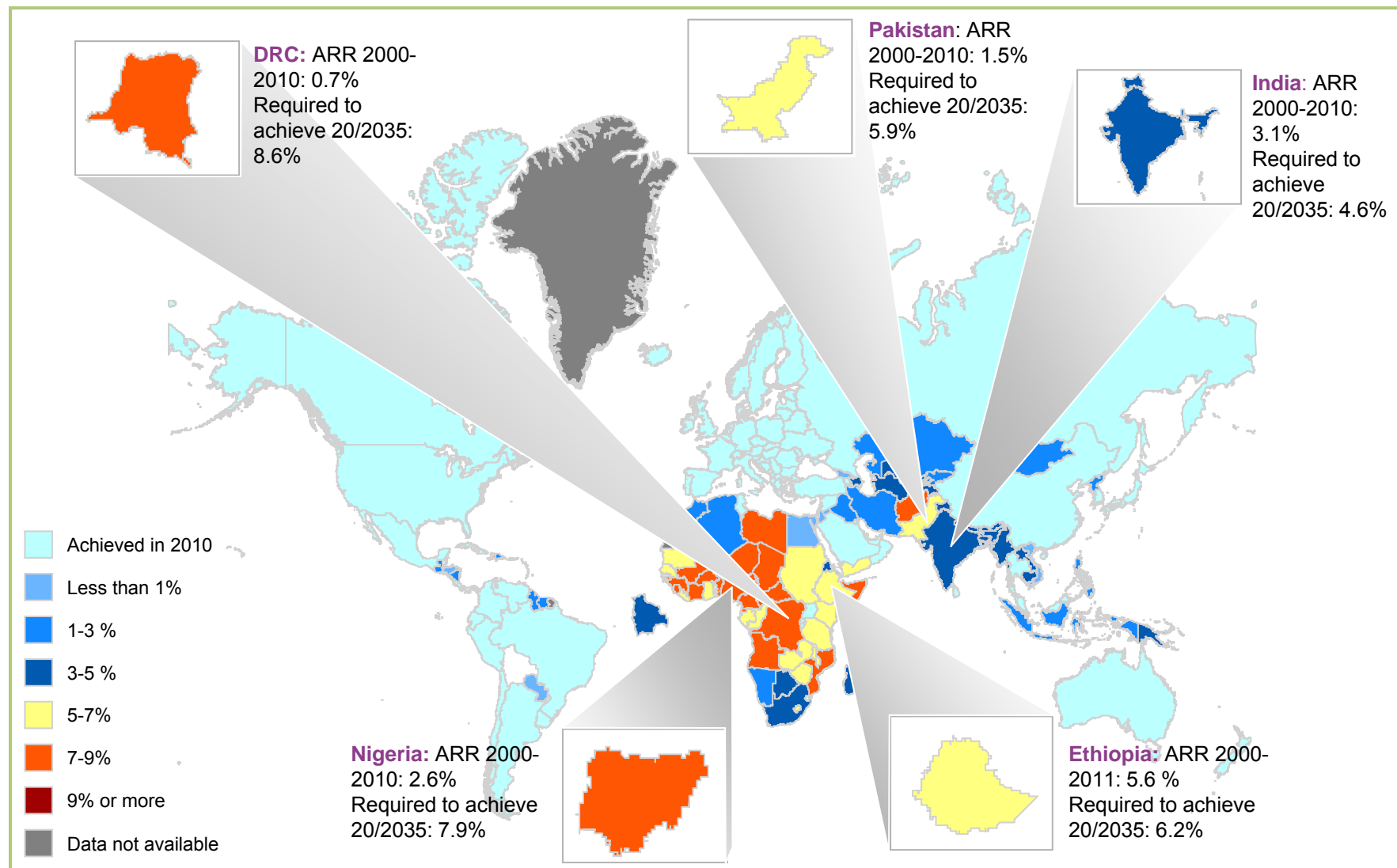


Source: UNICEF State of the World's Children 2012; The UN Inter-agency Group for Child Mortality Estimation, Levels and Trends in Child Mortality: Report 2011, 2011; Team analysis from 2035 onward based on straight-line ARR reduction from UNICEF numbers 1990-2035

CHILD SURVIVAL
CALL to ACTION

Many of the highest burden countries will need to significantly accelerate their current rates of reduction to achieve the MDGS and each reach, for example an U5MR of 20 / 1000 by 2035 ...

ARR needed for each country to achieve U5MR of 20 by 2035



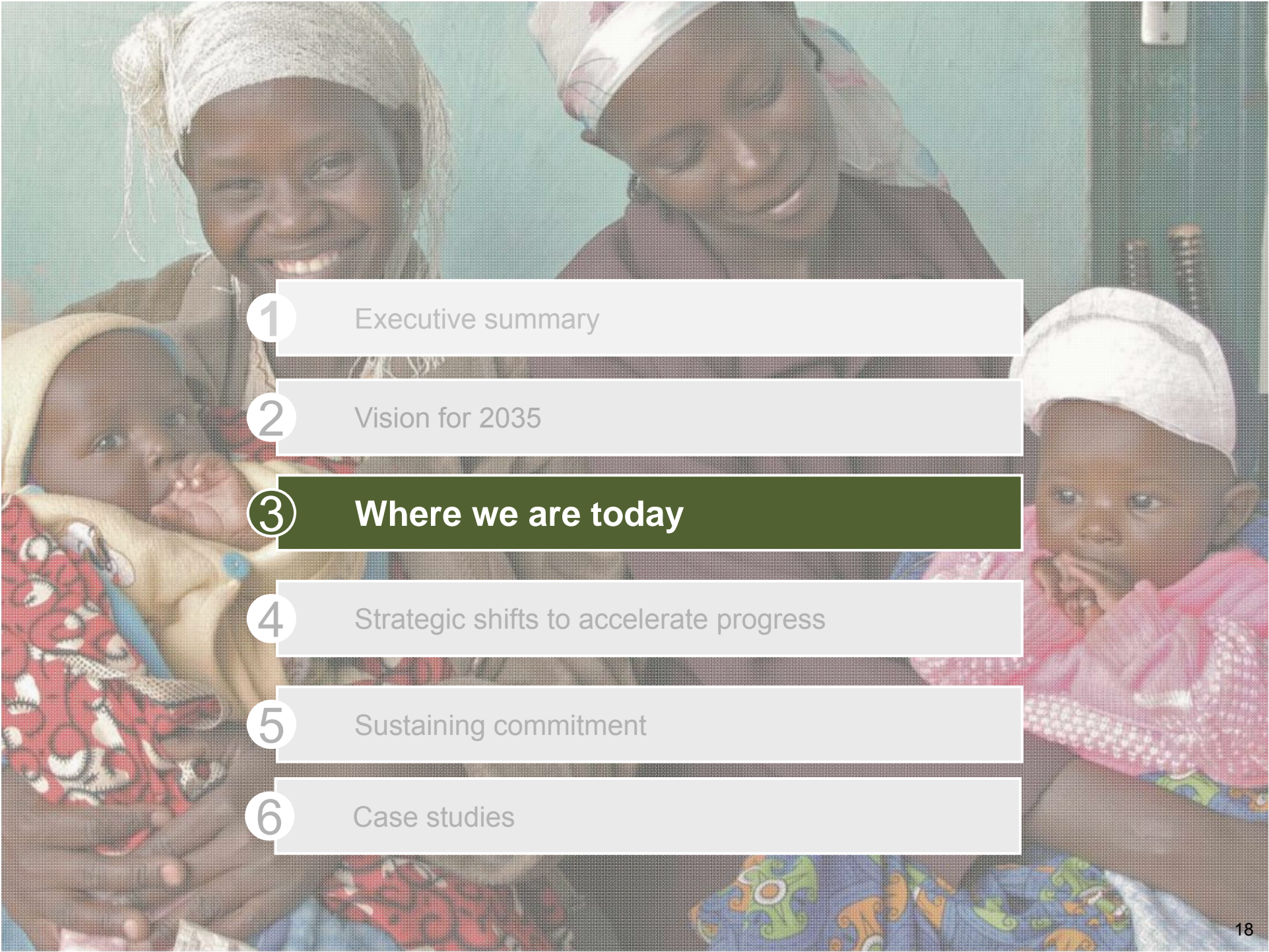
Acceleration is possible: many countries have achieved annual rates of decline above 5.2% in the past few years

NOT EXHAUSTIVE

Average annual rate of decline in under-five mortality rate, various years

Percent





1

Executive summary

2

Vision for 2035

3

Where we are today

4

Strategic shifts to accelerate progress

5

Sustaining commitment

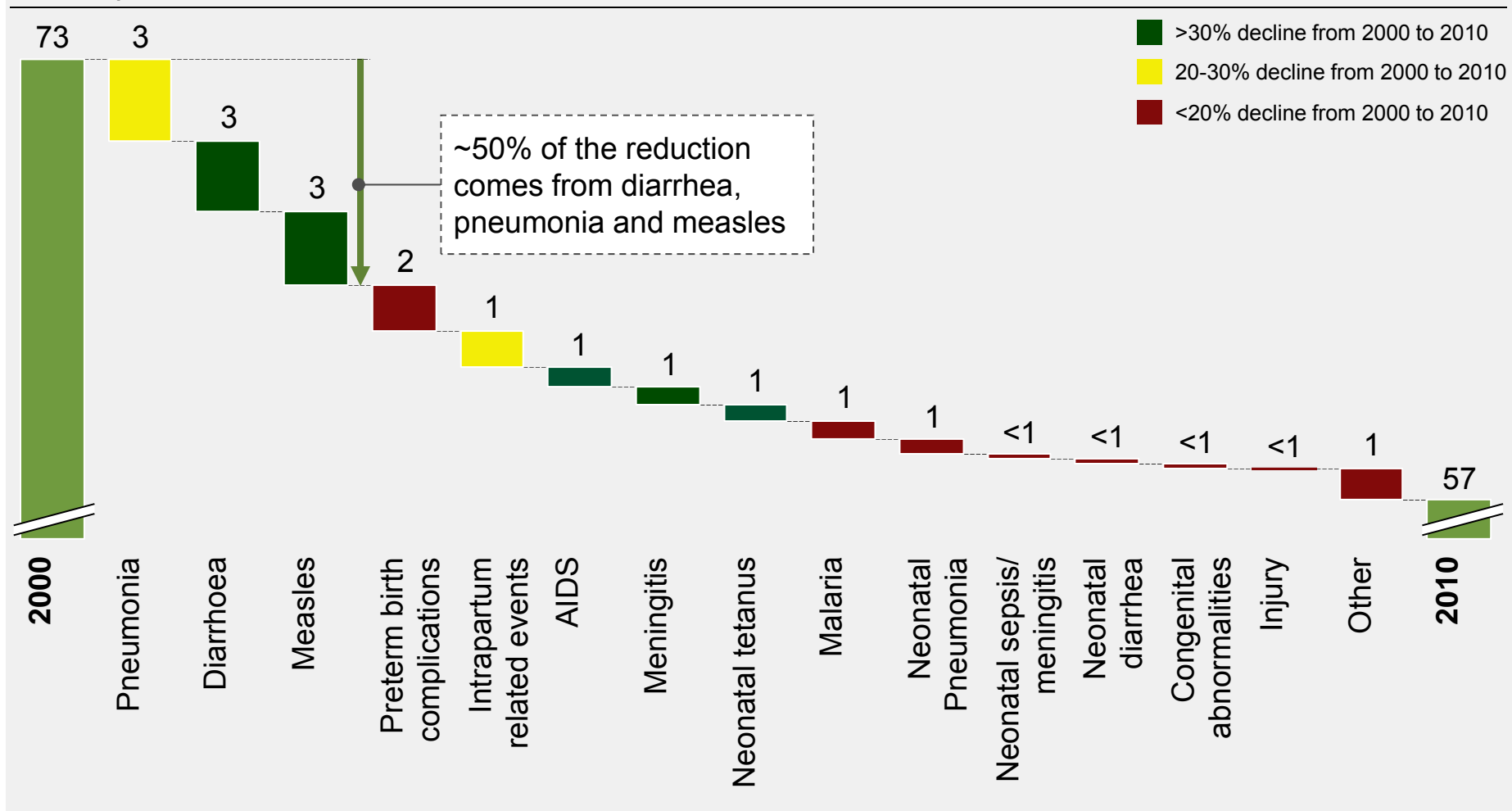
6

Case studies

Improving child survival has meant progress against a number of different causes of death and underlying contributors including malnutrition and birth spacing

Reduction in global U5MR by disease, 2000 to 2010

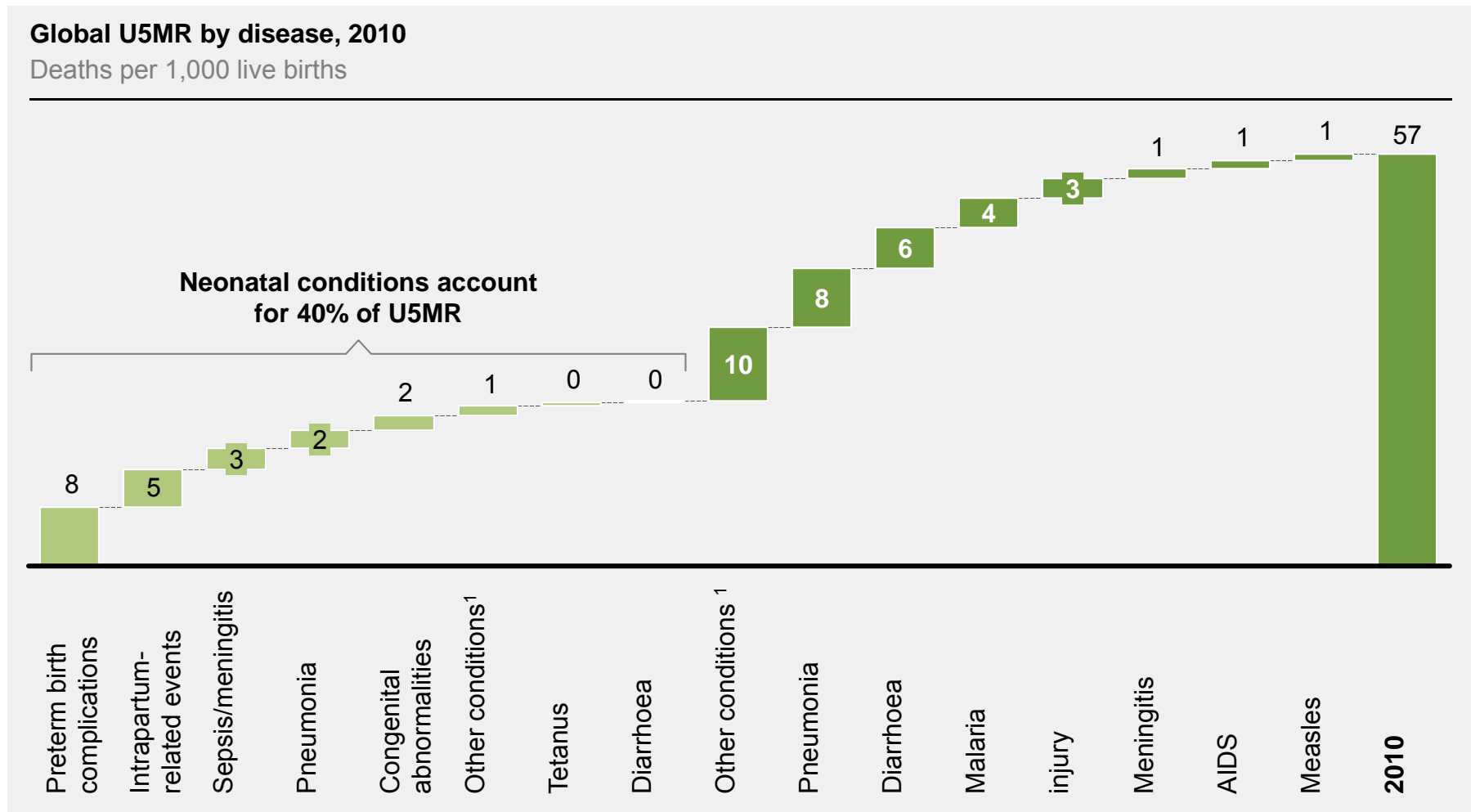
Deaths per 1,000 live births



1 Other includes other conditions for neonatal and non-neonatal causes of mortality; other conditions among children aged 1-59 months included congenital abnormalities, causes originated during the perinatal period, cancer, pertussis, severe malnutrition, pediatric TB and other specified causes.

Source: Liu et al. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000 (2012), The Lancet, Early Online Publication

Neonatal conditions, pneumonia, diarrhea, and malaria account for over 75% of under-five mortality.



¹ Other includes other conditions for neonatal and non-neonatal causes of mortality; other conditions among children aged 1-59 months included congenital abnormalities, causes originated during the perinatal period, cancer, pertussis, severe malnutrition, pediatric TB and other specified causes.

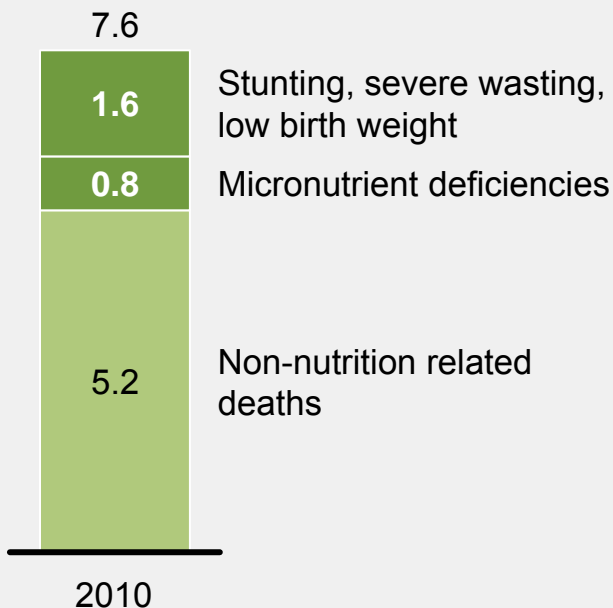
Source: Liu et al. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000 (2012), The Lancet, Early Online Publication

Preventing these deaths requires addressing underlying risk factors such as poor nutrition and inadequate birth spacing intervals

Nutrition-related factors are responsible for ~33% of child deaths

Total deaths in children under 5 years, 2010

Millions

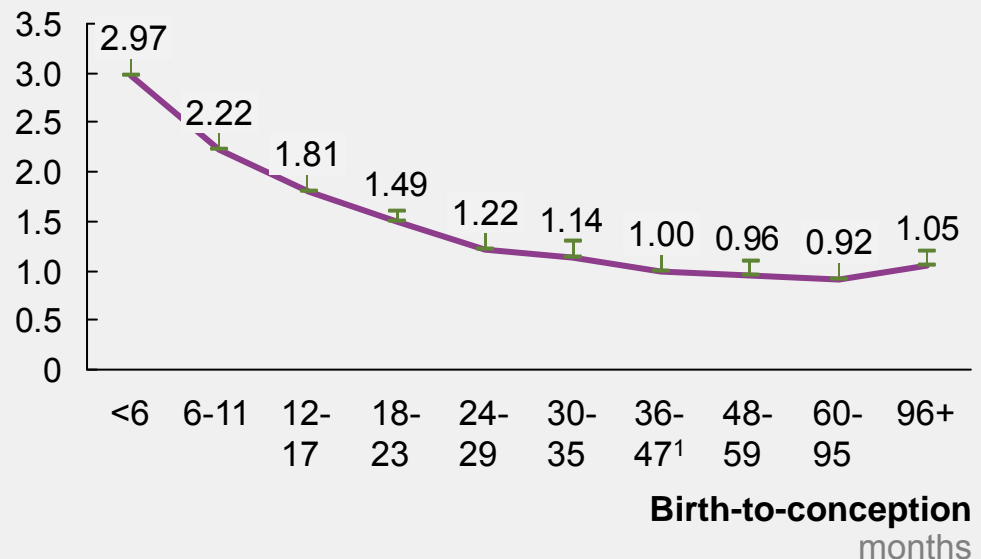


Malnutrition is a underlying cause of ~2.5 million child deaths a year

Other risk factors also contribute to child mortality

Under 5 mortality by birth-to-conception interval 52 demographic and health surveys

Adj. Relative Risk

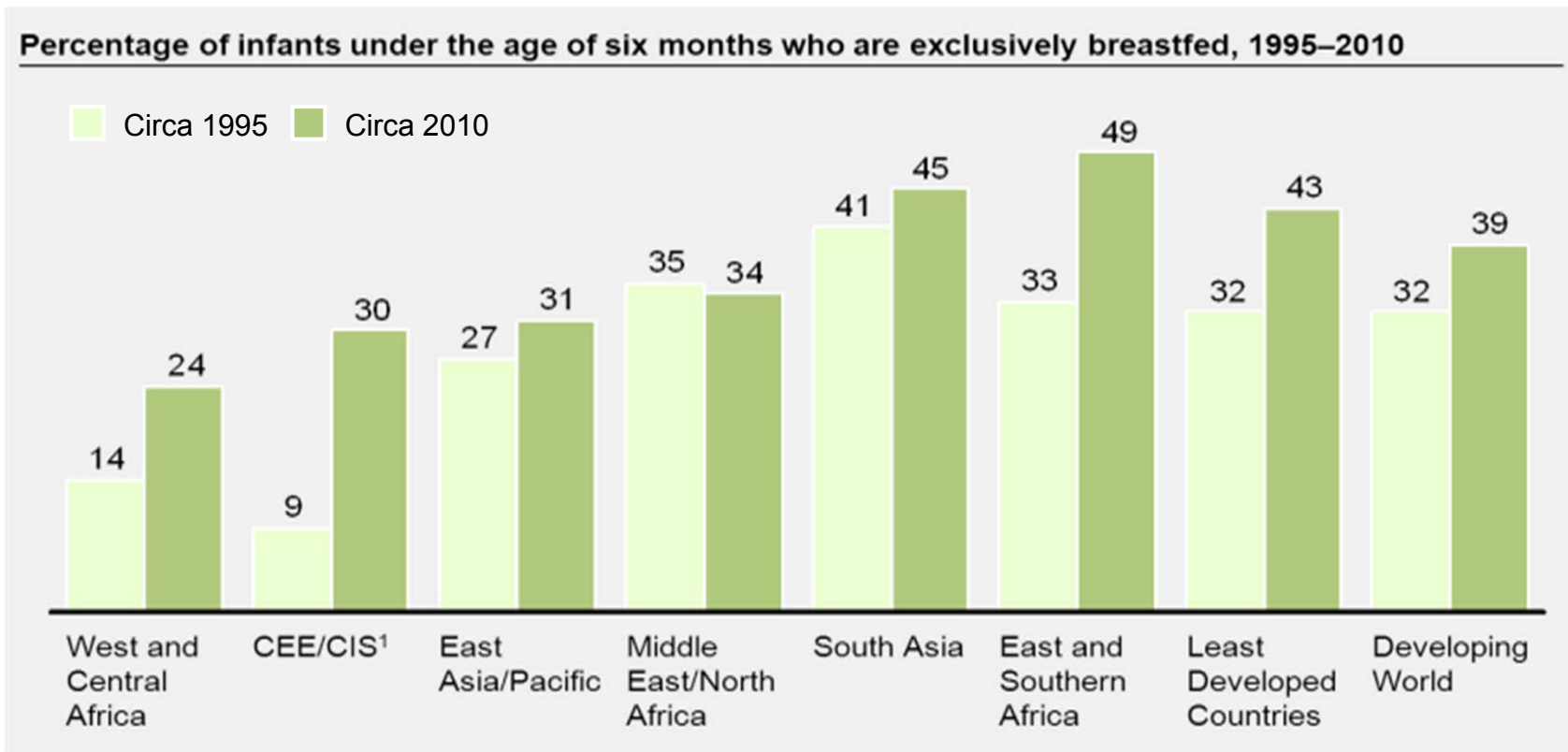


If all birth to pregnancy intervals were 3 years, ~1.6 million under-five deaths could be prevented annually

1 Ref. Group

Source: Save the Children 2012, "Nutrition in the First 1,000 Days" and "A Life Free From Hunger"; Black et al Maternal and child undernutrition: global and regional exposures and health consequences (2008), The Lancet; Rutstein, 2008; Baqui and Williams, 2008; Conde-Agudelo, 2000-2005; DaVanzo 2007; Report of a WHO Technical Consultation on Birth Spacing, Geneva, Switzerland, 13-15 June, 2005; USAID analysis; team analysis; Rutstein 2008

Important practices, such as exclusive breastfeeding, need more attention



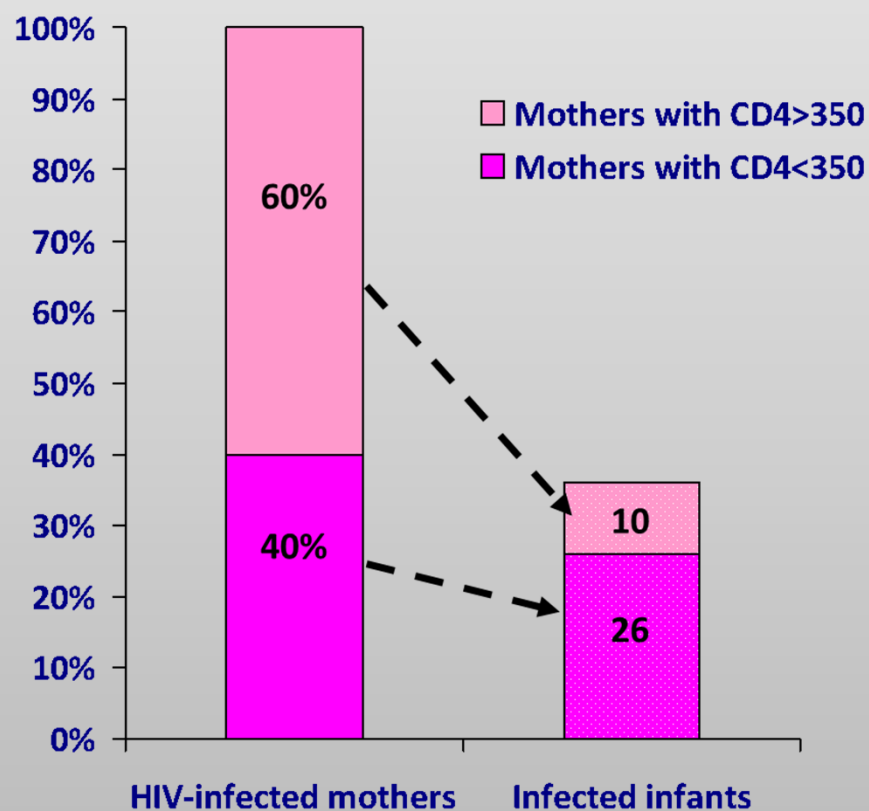
- Over the past 5–10 years, 23 countries have recorded gains of 20 percentage points or more
- Key success factors
 - Effective regulatory frameworks and guidelines e.g., on International Code of Marketing of Breast-milk Substitutes and maternity protection for working women
 - Use of comprehensive programmatic approaches at scale (e.g. join UNICEF/WHO action)
 - Starting breastfeeding in maternity facilities, counseling, mother-to-mother support groups in the community, communications tailored to the local context.

1 Central and Eastern Europe/Commonwealth of Independent States

Source: UNICEF, ChildInfo, Monitoring the Situation of Children and Women, “Progress,” January 2012, based on UNICEF global databases 2011, from Multiple Indicator Cluster Surveys (MICS), Demographic Health Surveys (DHS) and other national surveys.

Maternal anti-retroviral therapy improves maternal and child outcomes

- In the absence of any interventions ~36% of infants born to HIV+ women will become infected
- Women with CD4 counts <350 account for 80% of transmissions and 80% HIV-associated maternal mortality



Strong relationship between maternal health, HIV transmission risk and child survival

- Infants who are HIV infected are 17-30 times more likely to die
- When a mother with HIV dies, her children are at least 4 times more likely to die

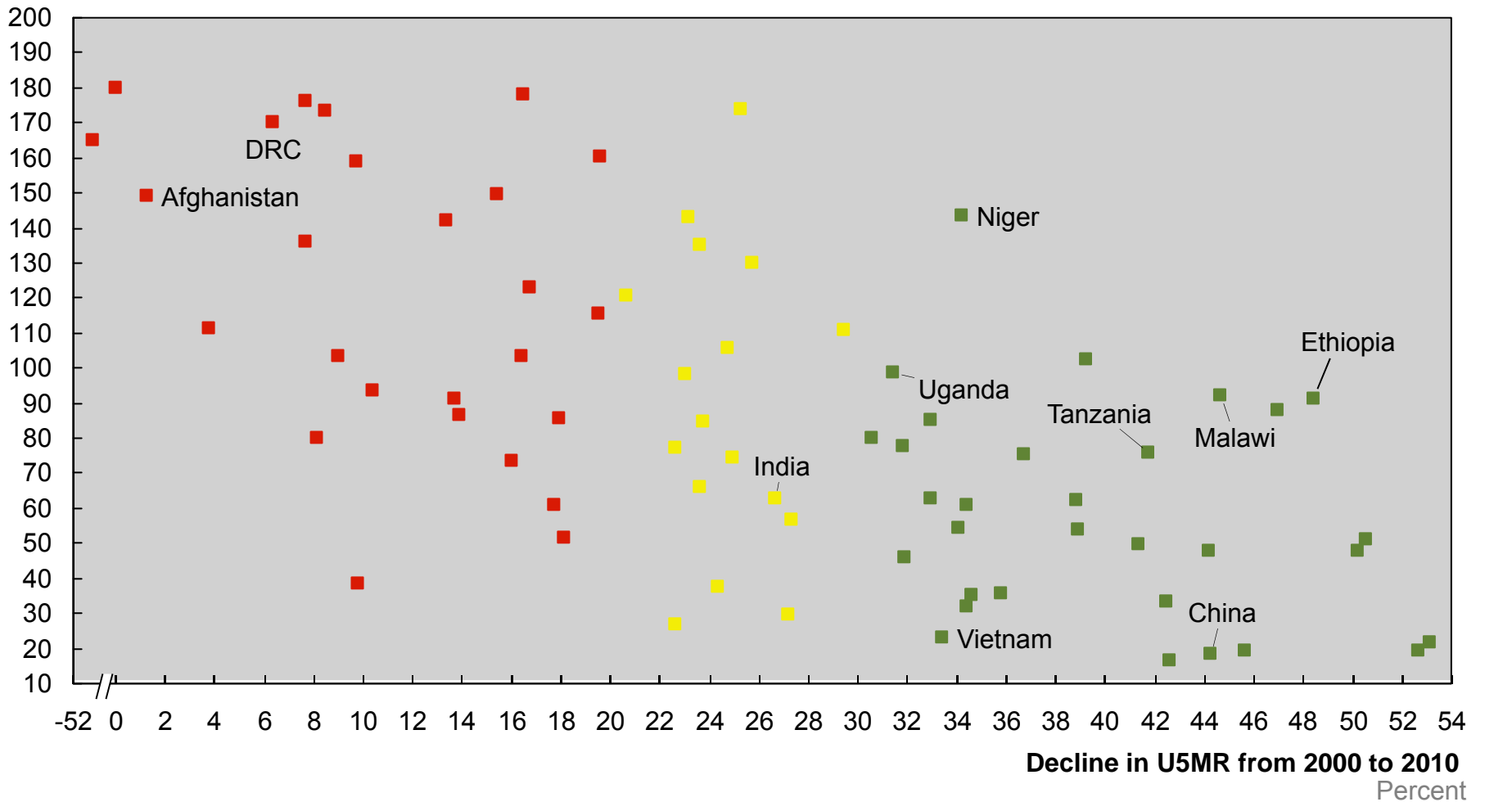
Treatment outcomes are highly favourable

- ART significantly improves CD4 counts, reduces maternal mortality and improves AIDS free survival
- Effective ARV prophylaxis and ART reduces peri-partum transmission to less than 2%
- ARV interventions also significantly reduce post-natal transmission
- HIV-infected mothers can breastfeed infants with minimal risk of transmission and thereby improve HIV-free survival

Accelerating progress is achievable with the right strategies – even in resource-constrained countries....

2010 U5MR Countdown Country comparison

Deaths per 1000 live births



Source: IGME data accessed from childmortality.org; Ethiopia 2011 DHS

... and with the strong leadership of local, national and global stakeholders working in collaboration through alliances and initiatives

Global partners

Global partners include:

- UNICEF
- World Health Organization
- USAID
- Norad
- THE WORLD BANK
- Sida
- DFID (Department for International Development)
- Save the Children
- Canadian International Development Agency / Agence canadienne de développement international
- JICA
- KOICA (Korea International Cooperation Agency)
- BILL & MELINDA GATES foundation
- afcd (Agence Française de Développement)

National and local

National and local stakeholders include:

- Mothers and children (Image of a woman and child)
- Faith communities (Logos for Christianity, Judaism, Islam, Hinduism, Buddhism, Sikhism, and others)
- Health ministries (Caduceus symbol)
- Civil Society (Image of raised hands)
- Community health workers (Image of a health worker with children)
- Private sector (Image of business meeting)

Global alliances and Initiatives

Global alliances and initiatives include:

- gain (Global Alliance for Improved Nutrition)
- ROLL BACK MALARIA
- GAVI ALLIANCE
- EVERY WOMAN EVERY CHILD
- The Partnership for Maternal, Newborn & Child Health
- GLOBAL POLIO ERADICATION INITIATIVE
- Scaling Up Nutrition
- MEASLES & RUBELLA INITIATIVE
- SAVING LIVES AT BIRTH: A GRAND CHALLENGE FOR DEVELOPMENT
- WaterAid
- mHealth Alliance
- PEPFAR (U.S. President's Emergency Plan for AIDS Relief)
- The Global Fund (To Fight AIDS, Tuberculosis and Malaria)
- newborn coalition
- CHILD SURVIVAL CALL to ACTION

The child survival community has rallied around evidence-based interventions across the continuum of care that benefit mothers and children ...

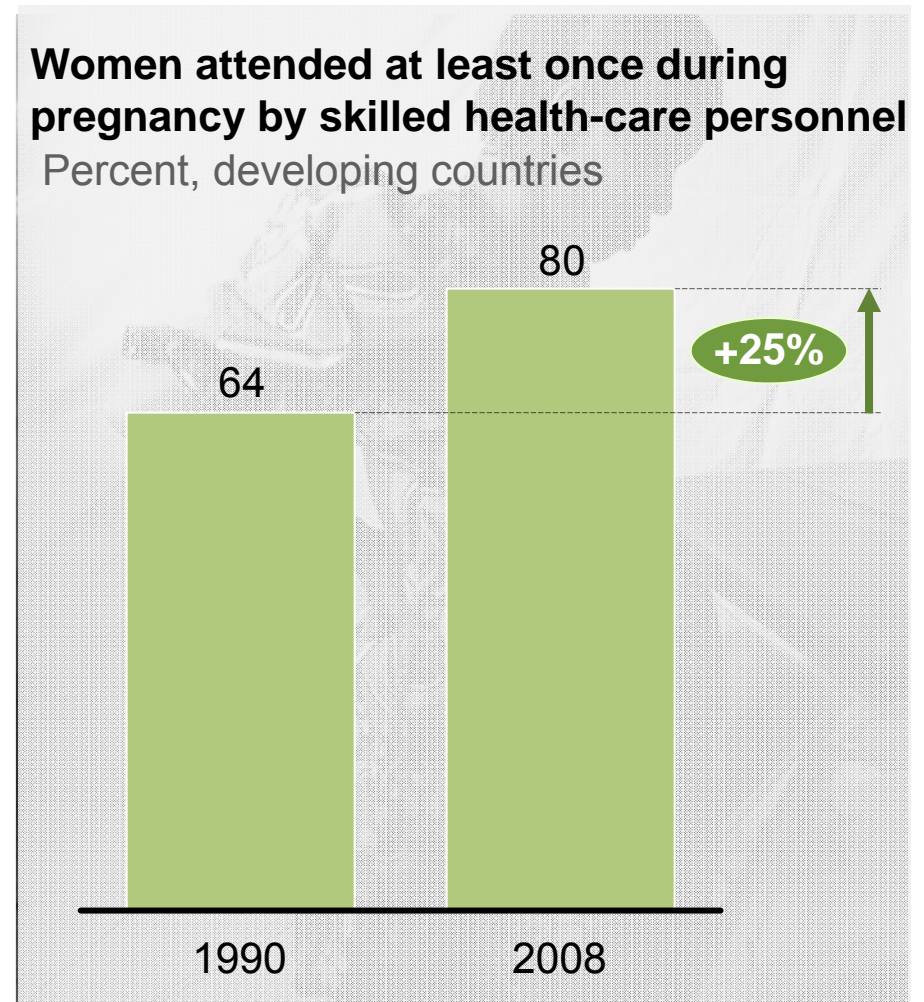
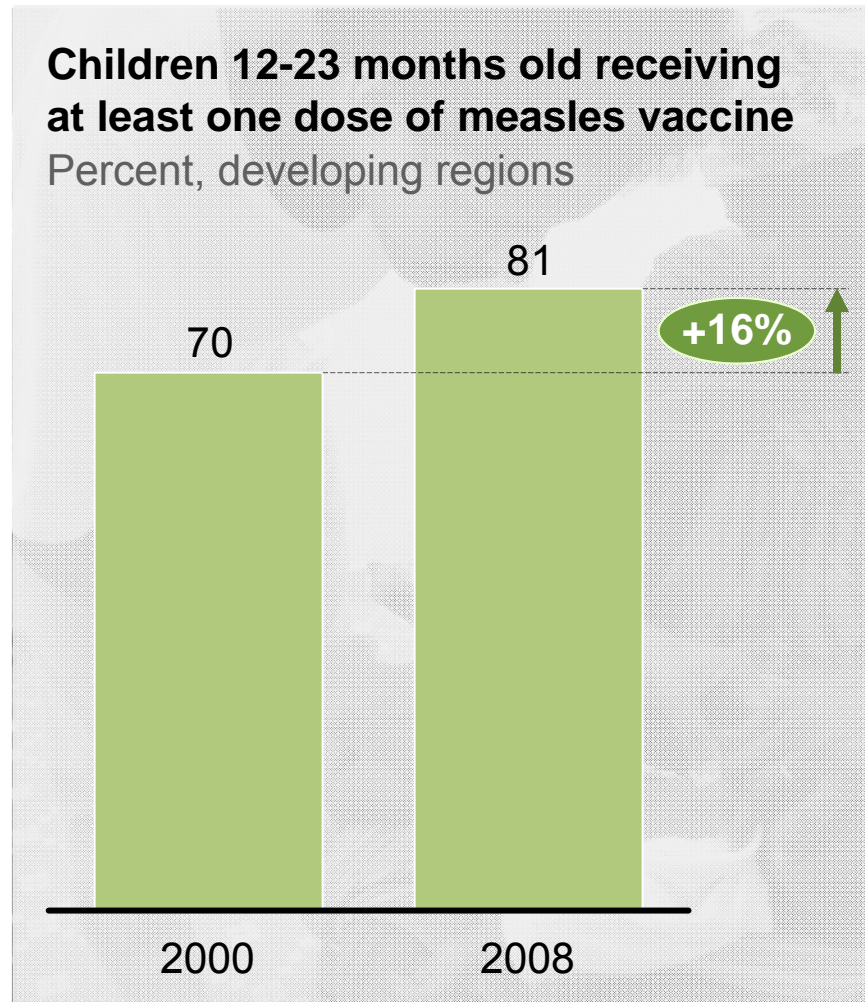
	Pre-pregnancy and Antenatal	Childbirth and postnatal	Infancy and Childhood
Preventive	<ul style="list-style-type: none"> Family planning/birth spacing counseling and service provision Prevent sexually transmitted infections, HIV Iron, folic acid supplementation Tetanus vaccination Smoking cessation Syphilis screening Mg sulphate and low dose aspirin to prevent pre-eclampsia, calcium to prevent hypertension Antibiotics for preterm labor Corticosteroids to prevent respiratory distress syndrome Antiretrovirals (ARVs) for HIV+ women and PMTCT 	<ul style="list-style-type: none"> Clean delivery Uterotonics and active management of third stage of labor to prevent postpartum hemorrhage Social support during childbirth Screen for HIV and follow up tracking Induction of labor for prolonged pregnancy Nutrition counseling Postpartum family planning methods Immediate thermal care Initiation of early breastfeeding/LAM Hygienic cord and skin care Kangaroo mother care for preterm or low birth weight babies Extra support for feeding small and preterm babies Antibiotic therapy for newborns at risk of bacterial infection Use of surfactant in pre-term babies Initiate prophylactic antiretroviral therapy for babies exposed to HIV 	<ul style="list-style-type: none"> Exclusive and continued breastfeeding Vitamin A supplementation from 6 months of age Zinc supplementation Other nutrition and growth monitoring Routine immunization of H. influenza, meningococcal, pneumococcal, measles, and rotavirus vaccines Prevention of childhood malaria Water, sanitation and hygiene Link immunization to family planning
Treatment	<ul style="list-style-type: none"> Syphilis treatment Antihypertensive drugs Magnesium sulphate for eclampsia Management of sexually transmitted infections and HIV Induction of labor at term to manage pre-labor rupture of membranes 	<ul style="list-style-type: none"> Manage postpartum hemorrhage Caesarean section for maternal/fetal indication with prophylactic antibiotics Treat maternal anemia Neonatal resuscitation with bag and mask Continuous positive airway pressure to manage respiratory distress syndrome Case management of neonatal sepsis, neonatal meningitis, and pneumonia 	<ul style="list-style-type: none"> Case management of meningitis, malaria, diarrhea, pneumonia, and severe acute malnutrition Comprehensive care of HIV including ARVs, cotrimoxazole, nutrition support, and psychosocial support

Source: Adapted from Jones *et al.* How many child deaths can we prevent this year? (2003) *The Lancet* 362: 65–71; PMNCH. 2011. Global Review of the Key Interventions Related to Reproductive, maternal, Newborn and Child Health. Geneva, Switzerland: PMNCH.

... and has increased coverage of these interventions

EXAMPLES

Mean coverage

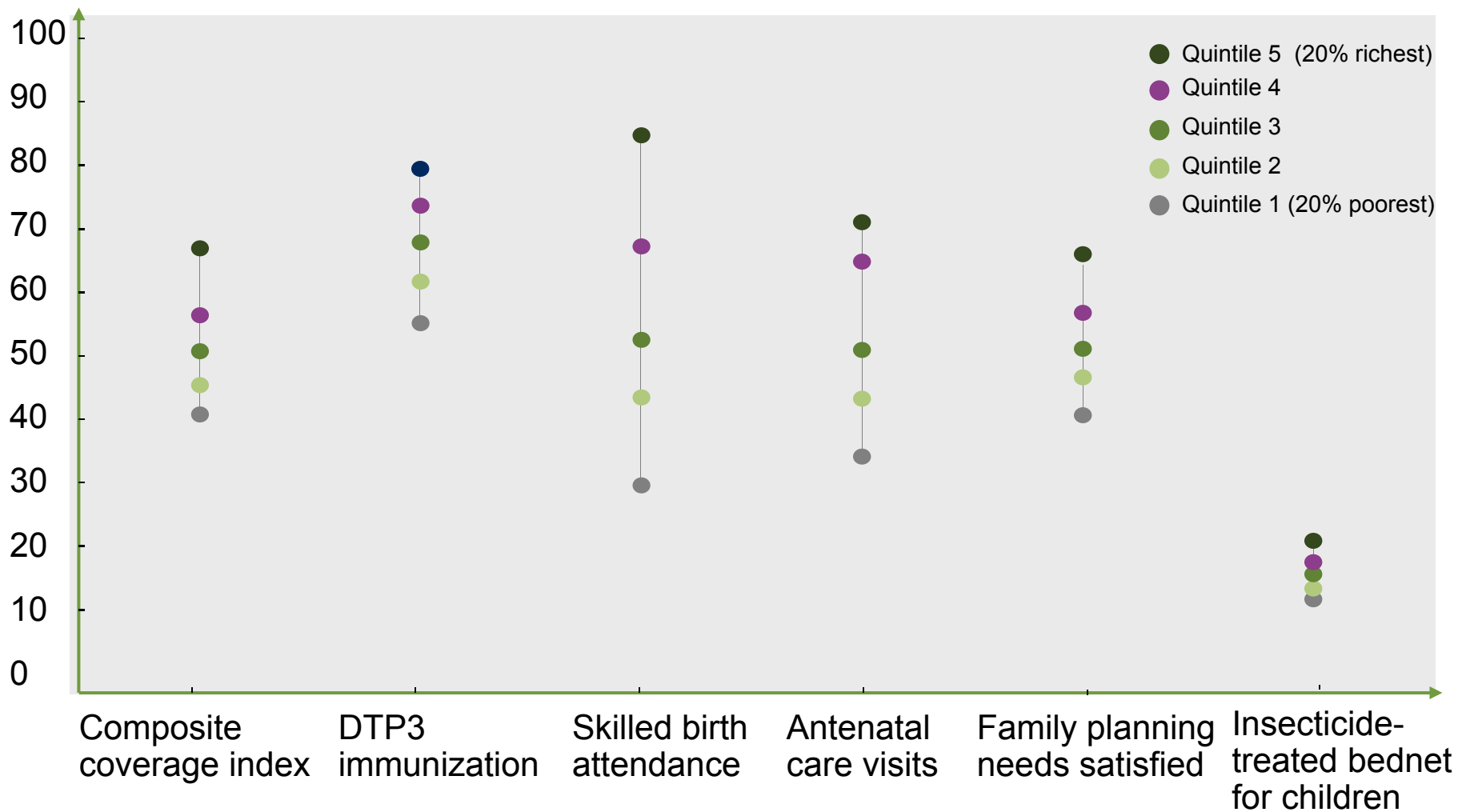


However, coverage is inequitable, not reaching the poorest in both rural and urban settings

NOT EXHAUSTIVE

Mean coverage in 54 countdown countries

Percent

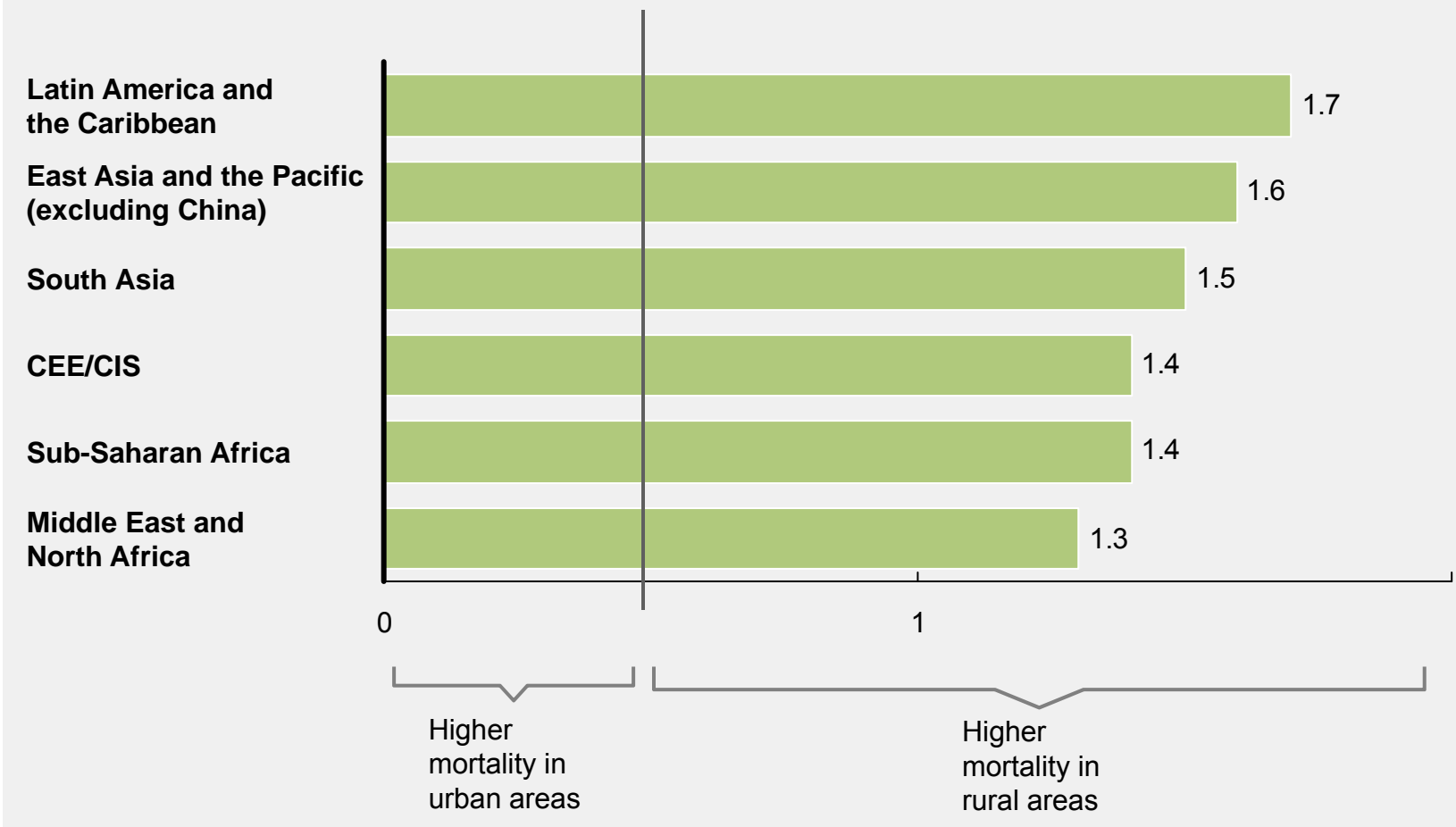


Source: Barros et al. Equity in maternal, newborn, and child health interventions in Countdown to 2015: a retrospective view of survey data from 54 countries (2012) The Lancet

Disparities in health outcomes persist in important populations

Across all regions, under-five mortality is higher in rural areas

Ratio of under-five mortality areas to urban areas, by region, 2008



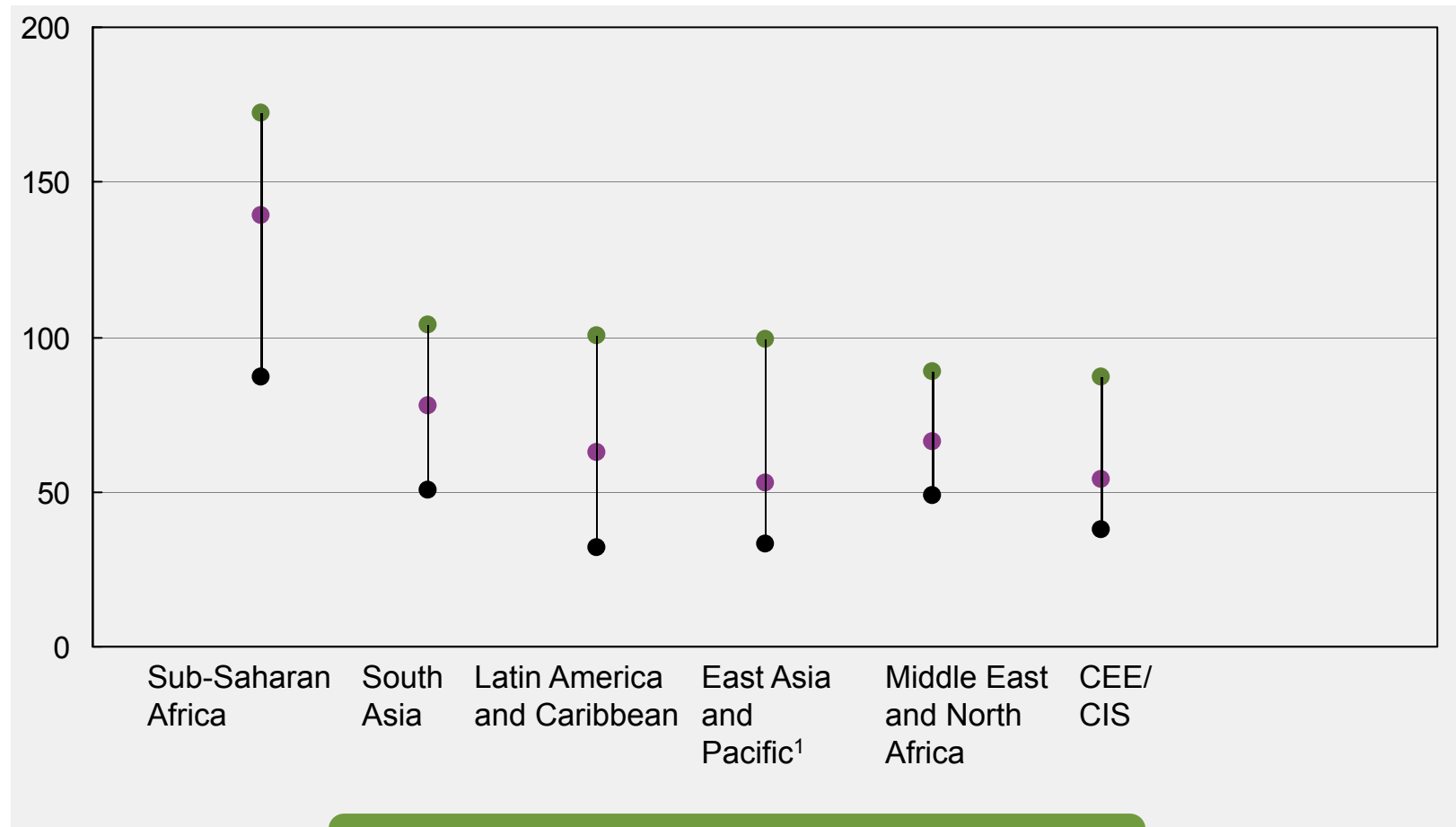
Disparities in education also correlate with disparities in death rates in all regions studied

EXAMPLE

- No education
- Primary
- Secondary or Higher

Under-five mortality rate, by mother's education level, by region

Death per 1,000 live births



Inter-sectoral coordination will be required to address girls' education impacting child survival

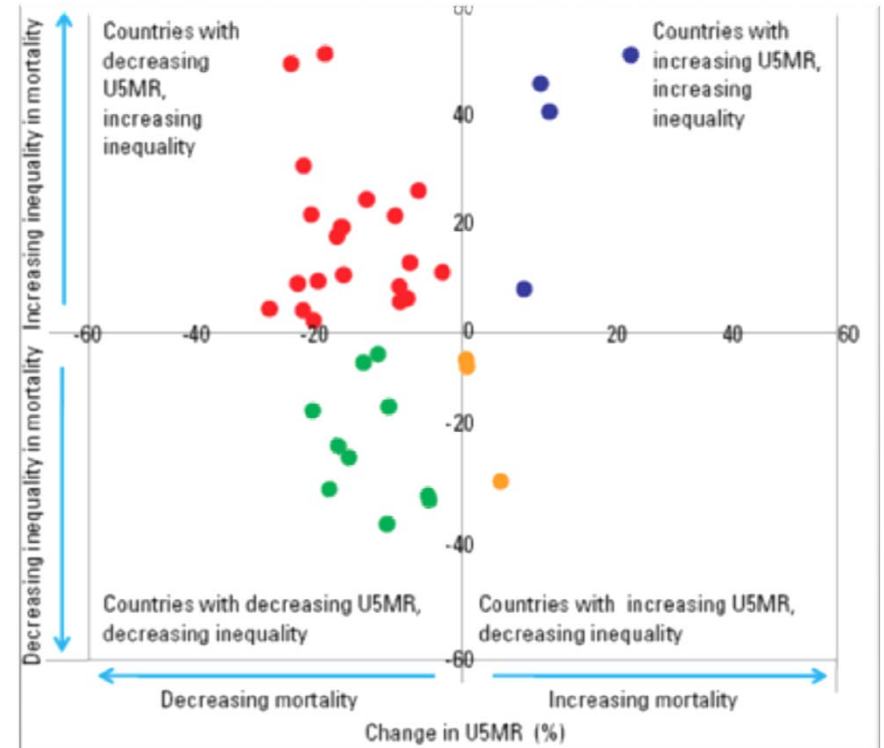
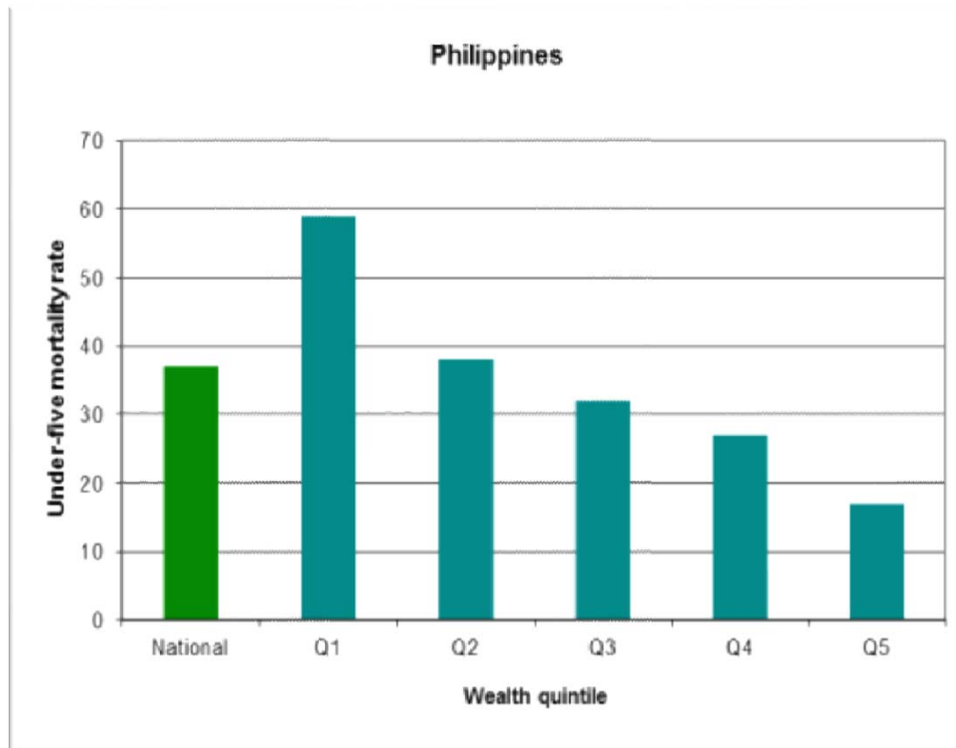
¹ Excludes China

Source: UNICEF, Progress for Children: Achieving the MDGs with Equity, 2010

Even where national indicators improve, inequality might still be a problem

“In many countries in which the under-five mortality rate has declined, disparities in under-five mortality by household wealth quintile have increased or remained the same”

UNICEF Progress for Children, 2010



- National averages can mask critical disparities by wealth quintile, urban-rural residence, and gender
- “Success” means reaching 20/1000 or below in every segment of society



1

Executive summary

2

Vision for 2035

3

Where we are today

4

Strategic shifts to accelerate progress

5

Sustaining commitment

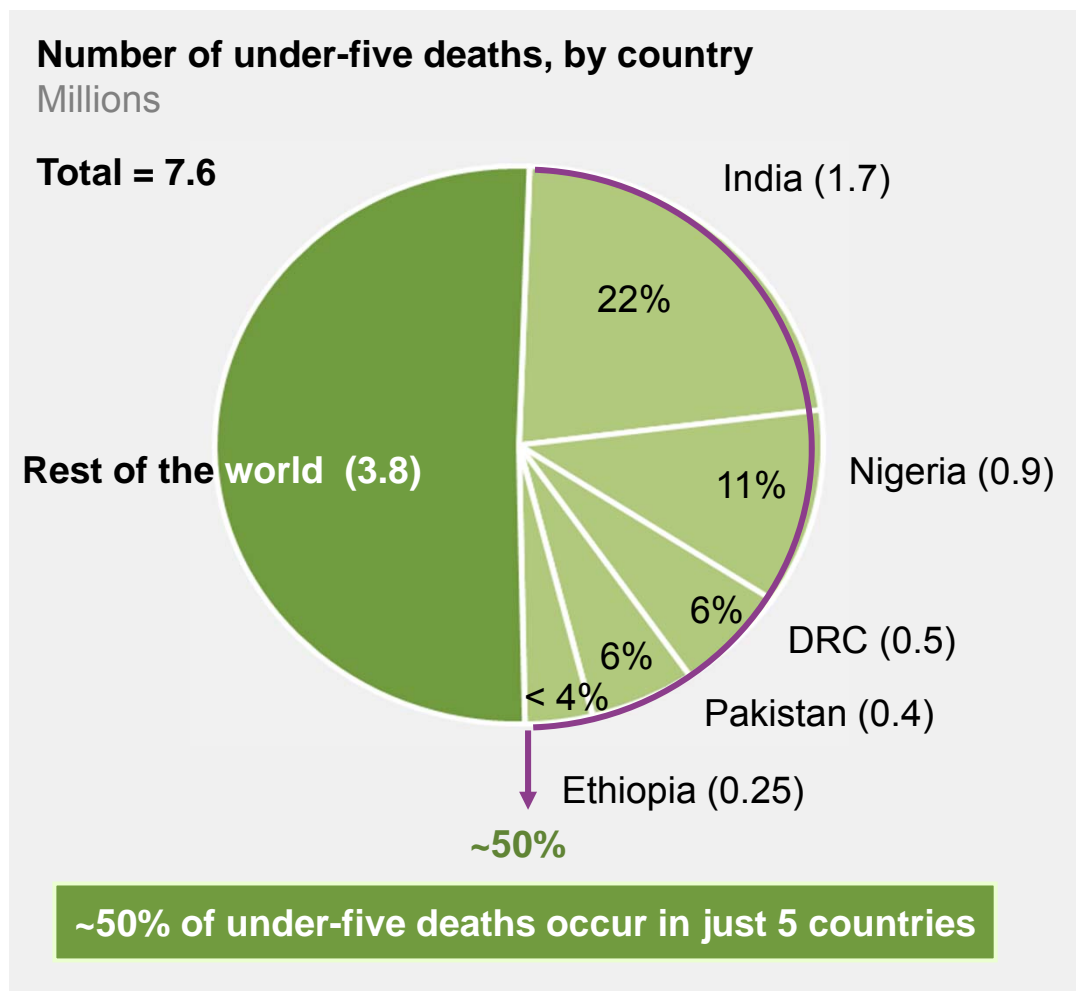
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Case studies

Ending preventable child deaths requires a new way of “doing business”. Evidence points to five strategic shifts that would accelerate progress in countries and globally

- 1 Geography**
 - Increase efforts in the 5 countries where half of under-five deaths occur, prioritizing budgets and committing to action plans to end preventable child deaths
- 2 High burden populations**
 - Re-focus country health systems on scaling-up access for underserved populations, e.g., rural and urban low income groups
- 3 High impact solutions**
 - Target the biggest opportunities for impact, e.g., neonatal conditions
 - Scale and sustain demand and supply of highest impact, evidence-based solutions
 - Invest in innovation (including operations research) to accelerate results
- 4 Education
Empowerment
Economy
Environment**
 - Educate girls and women
 - Empower women to make decisions
 - Enact smart policy for inclusive economic growth
 - Environmental factors addressed e.g., sanitation and hygiene
- 5 Mutual accountability**
 - Create transparency and mutual accountability for results from global to local levels
 - Unify child survival voice with a shared goal and common metrics (e.g., ARR).
 - Invest in systems to capture data, monitor and evaluate progress and share knowledge
 - Update Roadmap to reflect state of knowledge and progress

1 Geographic focus: under-five mortality is highly concentrated – 80% of the burden is in 24 countries representing 6 million deaths/year; 5 countries contribute nearly half of all child deaths (3.8 million/year)



- 50% of child deaths occur in just 5 countries
- 24 countries account for 80% of deaths worldwide
- Accelerating progress in these countries can have significant impact on under-five mortality
- The global community needs to collaborate more closely with the high burden countries to overcome barriers to successful, sustainable child health programs

Source: The UN Inter-agency Group for Child Mortality Estimation, Levels and Trends in Child Mortality: Report 2011, 2011; Liu et al. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000 (2012), The Lancet, Early Online Publication; Ethiopia MoH and DHS data

2 Scaling up health services access for rural and low-income populations

- The child mortality burden is disproportionately concentrated in poor and marginalized communities
 - In Nigeria, 33% of all child deaths occur in the poorest quintile; 7% occur in the wealthiest quintile
- Equity-based approaches focusing on expanding services and reducing disparities in essential services and out-of-pocket expenditures for the poor have the potential to achieve a 50% reduction in U5MR among the most excluded populations
- Effectively increasing health outcomes for the poor requires:
 - Enacting policies to expand health care coverage, e.g., enacting free health care as a constitutional right or enacting task-shifting regulations
 - Community-based delivery platforms providing packages of essential health services
 - Minimizing barriers to use, e.g., eliminating user fees or reducing transport costs
 - Significant barriers exist e.g. populations hard to locate, hard to reach, little political voice, may have special needs and therefore solutions need to be adapted

2 Increasing access for the poorest populations could reduce U5MR by 50% in the most excluded areas

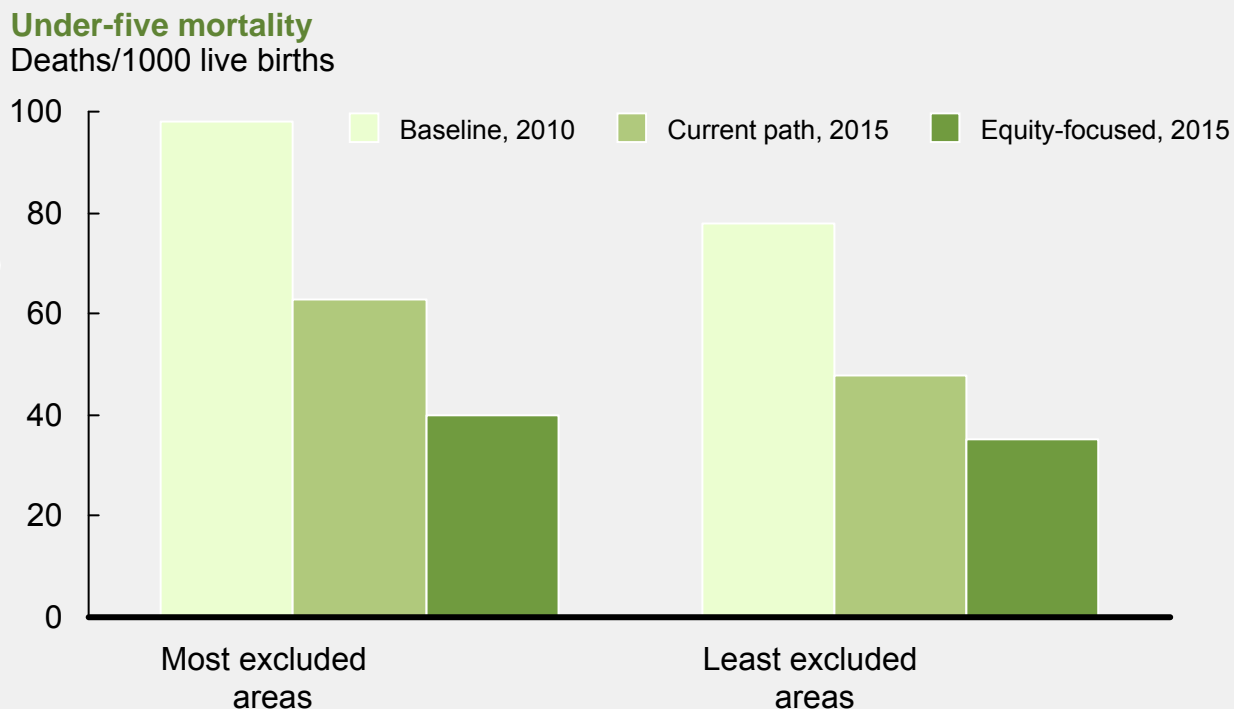
An equity-focused approach focuses on reducing disparities in essential services and out-of-pocket expenditures for the poor

Implementing strategies targeted at increasing access to the poor...

- **Upgrading facilities for maternal and newborn care and expanding maternity services at the primary level:** e.g., maternity “waiting homes”
- **Overcoming barriers to utilization:** e.g., expanding outreach services, eliminating user charges
- **Task shifting:** e.g., increased use of community health workers to deliver basic health-care services where appropriate

... can accelerate the decline in U5MR for poor populations

Modeled impact of equity-focused approach in 2015



Based on the analysis of 15 countries: Bangladesh, Benin, Ghana, Honduras, Kenya, Mali, Niger, Nigeria, Pakistan, Philippines, Rwanda, South Africa, Uganda, Vietnam, and Zimbabwe; most and least excluded areas for each country are determined by coverage levels of essential primary health care services

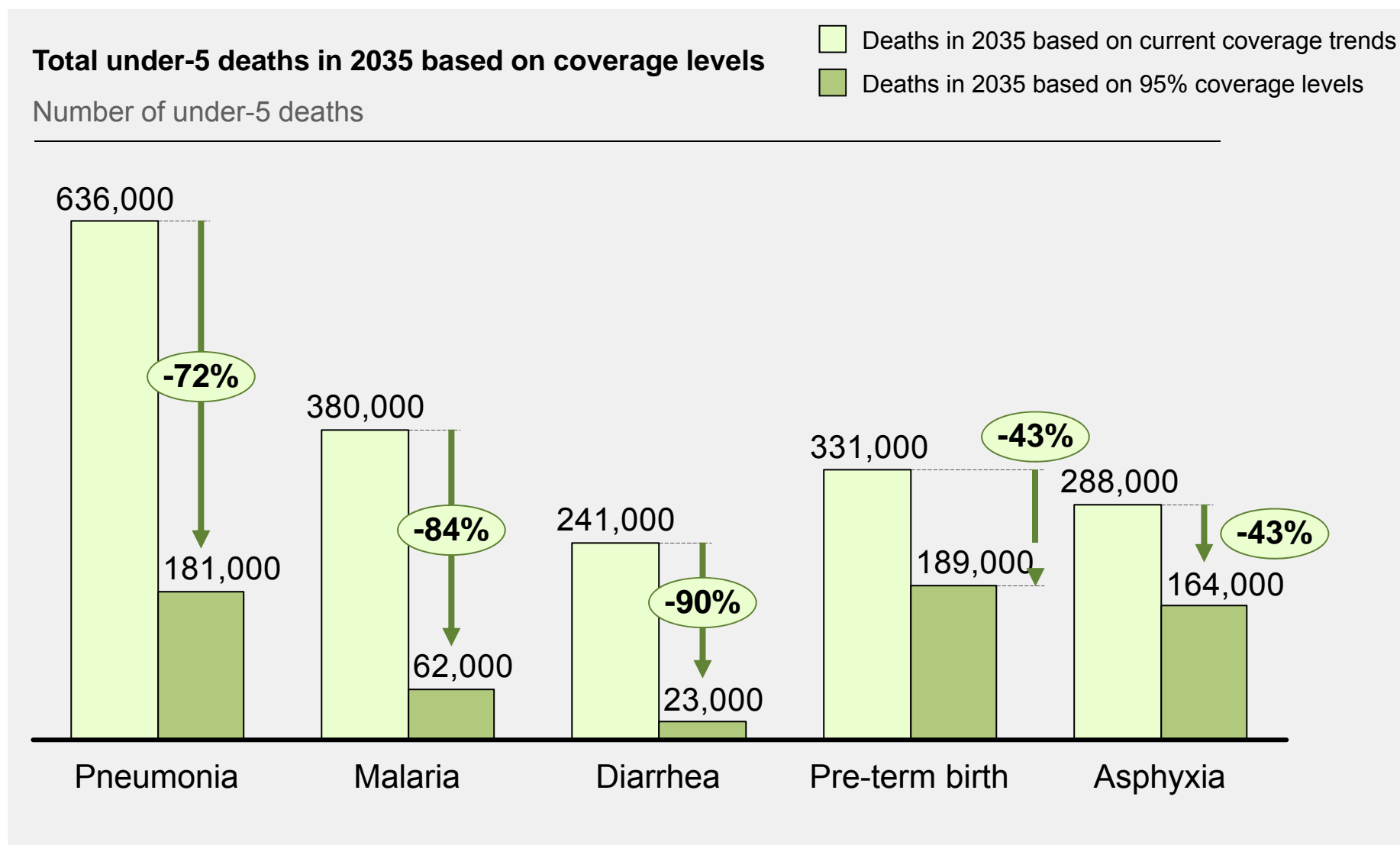
Source: UNICEF 2010 “Narrowing the Gaps to Meet the Goals”

3 High impact solutions: focusing on priorities

- ❑ **Five causes account for over 50% of child deaths: Pneumonia, diarrhea, malaria, preterm births and intrapartum related events, but global attention to them is not commensurate with their burden**
- ❑ **Countries must systematically prioritize the top causes of mortality and the interventions that have the largest potential for sustained impact**
 - Rwanda systematically prioritized and scaled up interventions to address malaria, pneumonia, diarrhea and neonatal causes of death over the last ten years, with a resulting fall in under-five mortality of almost 50% from 2005 to 2010*
 - Scaling up and sustaining the priority cost-effective interventions could reduce mortality by 35-50 % in the highest burden countries
- ❑ **Countries must address neonatal conditions to reach their U5MR targets**
 - Egypt reduced its U5MR by 7% a year over 20 years by focusing on neonatal conditions, scaling up voluntary family planning, and expanding its facility-based care to provide better maternal care and safe delivery*
- ❑ **Underlying factors such as nutrition and birth spacing are critical**
 - Tanzania has elevated nutrition as a top priority for economic growth and development with the comprehensive plan to reduce stunting from 42% to below 22%*

* See country case profiles in the last section of this document

3 Insufficient scale exists today: achieving coverage at scale of effective interventions for the top 5 causes could save an additional ~1.3M lives annually by 2035



1 For 74-75 countdown countries

Source: Lives Saved Tool modeling by Johns Hopkins Bloomberg School of Public Health 2012

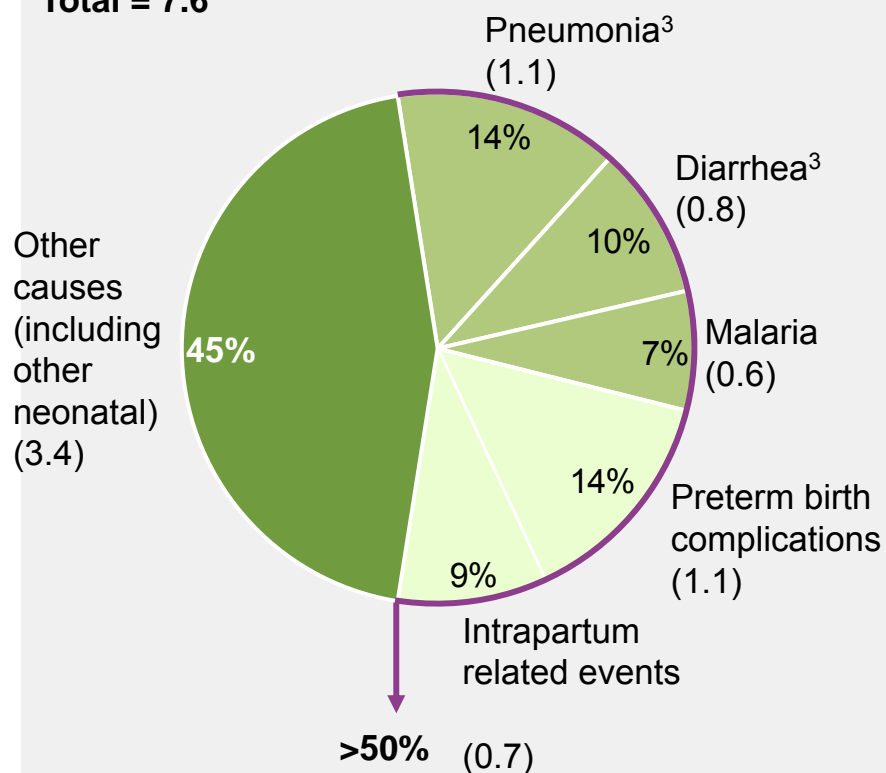
3 Investments and focus should better track need and potential impact

>50% of under-five deaths are due to 5 causes of mortality

Number of under-five deaths, by cause of mortality, 2010

Millions

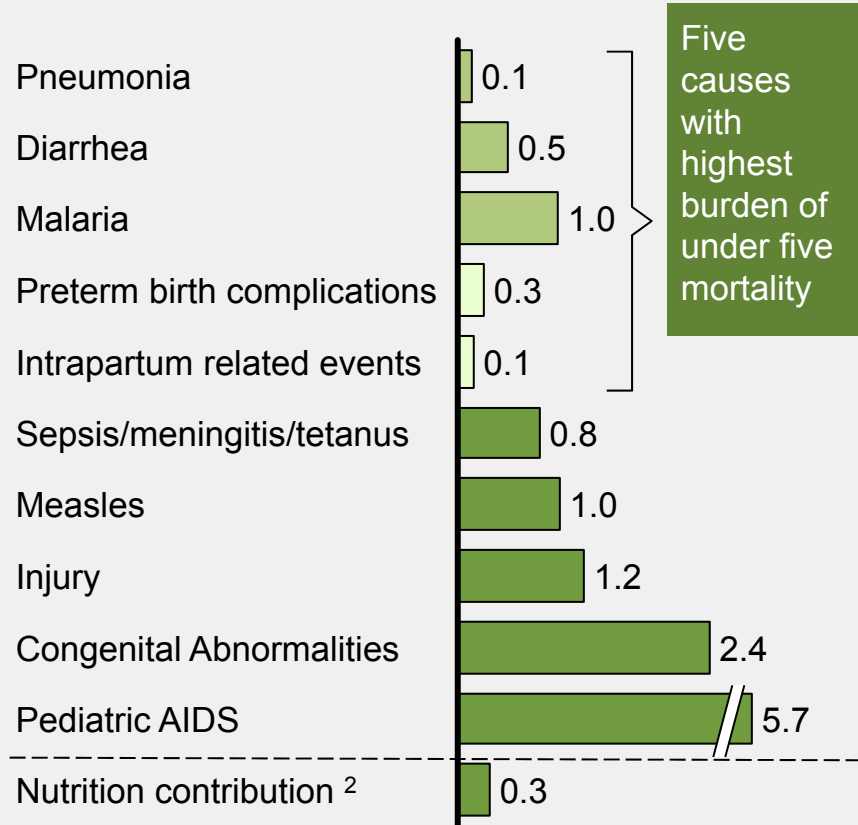
Total = 7.6



Attention to highest burden causes is small relative to their mortality burden¹

Ratio of articles on child health in Countdown countries (Jan 2011 to May 2012) to absolute U5M¹

Articles per thousands of U5 deaths



1 May 17, 2012 PubMed search for (Cause_name[Title/Abstract]) AND (Countdown_country1...OR...Countdown_country75 [Title/Abstract]) AND (child OR neonate OR infant[Title/Abstract]) AND ("2011/01/01"[PDAT] : "3000"[PDAT])

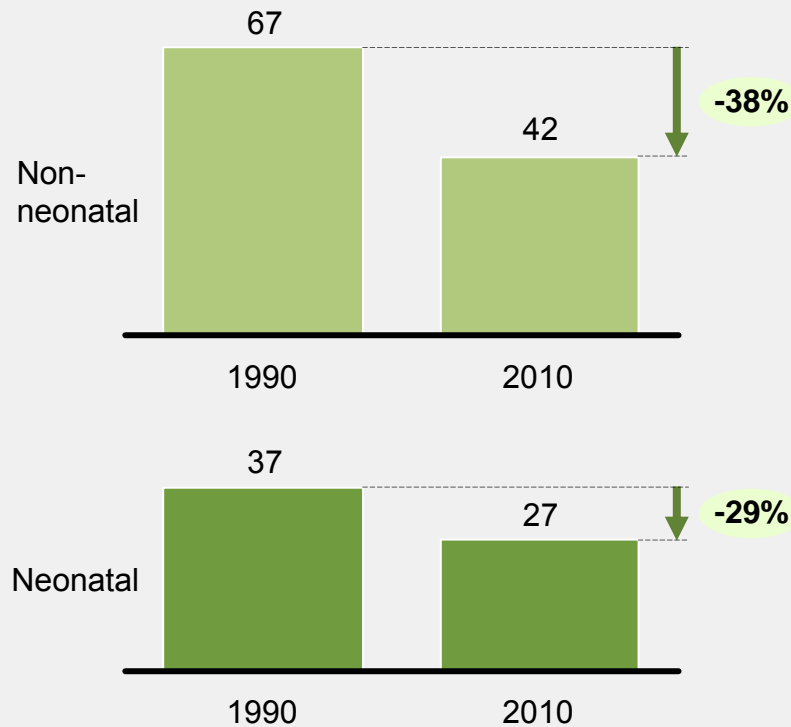
2 Assumes nutrition contributes to 33% of U5M; Black et al, Maternal and Child Undernutrition Series, Lancet 2008

3 Excluding neonatal pneumonia and diarrhea.

Countries must address neonatal conditions to reach their targeted U5MR¹

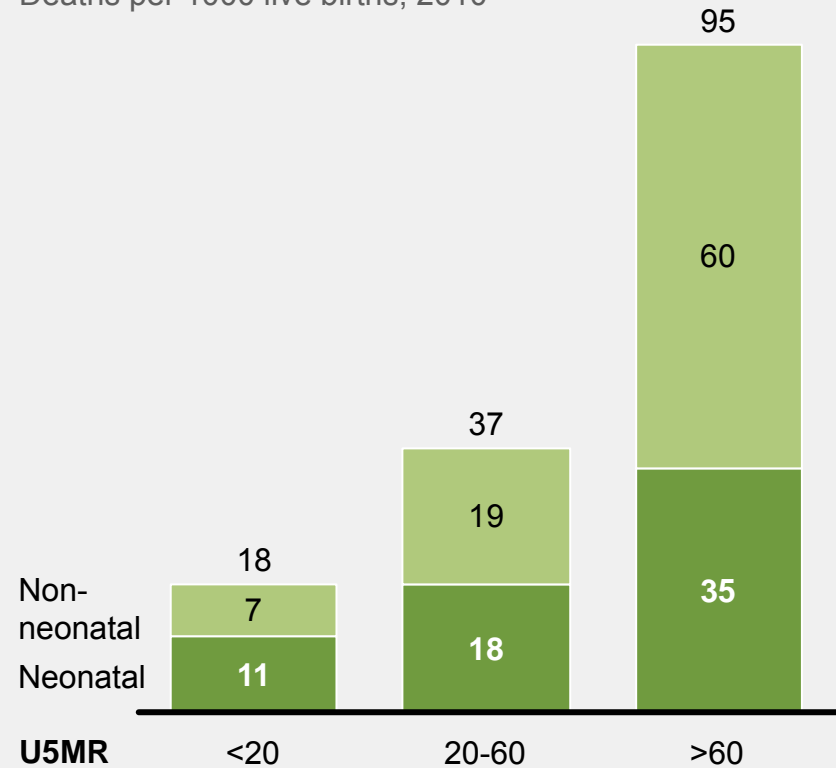
Progress on neonatal survival lags that of overall under-five progress

Under-5 mortality rate, countdown countries
Deaths per 1000 live births



As countries achieve lower U5MR, neonatal mortality constitutes a higher percentage of overall burden

Under-5 mortality rate, countdown countries
Deaths per 1000 live births, 2010

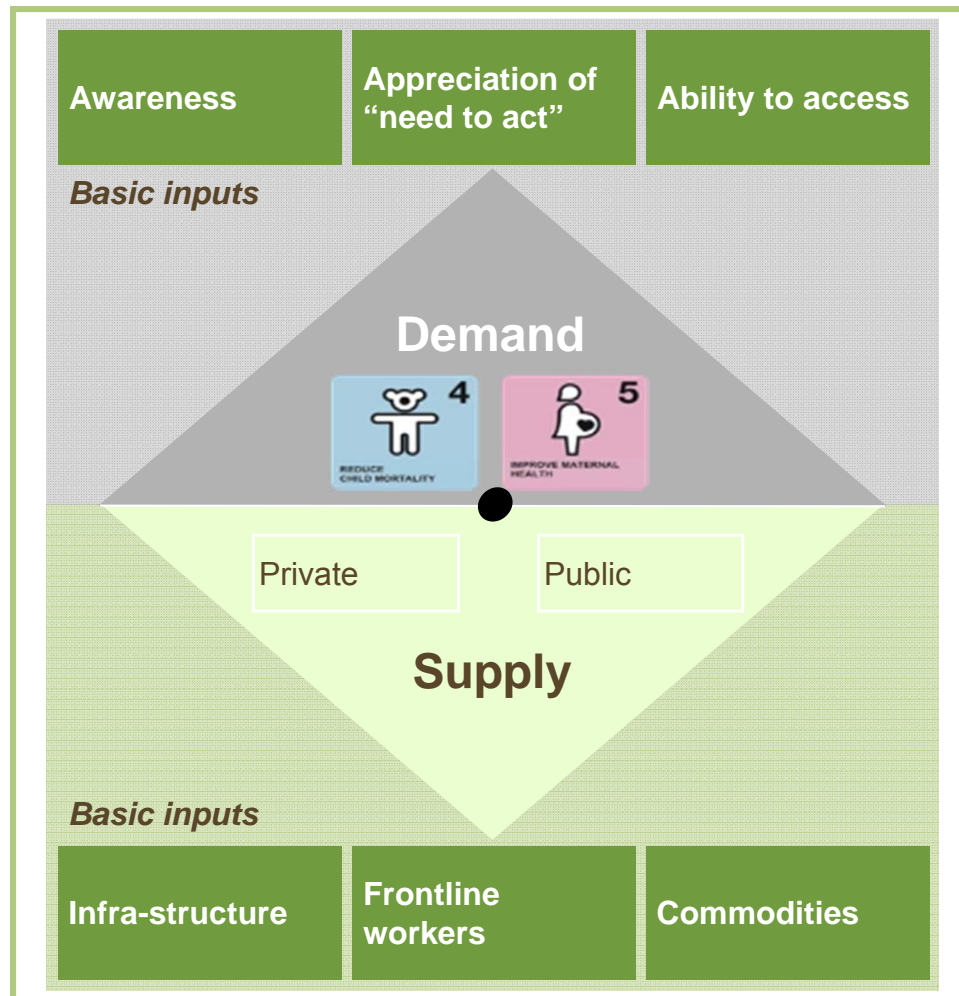


Reaching 15 by 2035 is not realistic without significant progress against neonatal mortality rate

¹ Rates are calculated using absolute numbers of child deaths divided by live births from respective year. This offers close approximation of mortality rates calculated with age cohorts

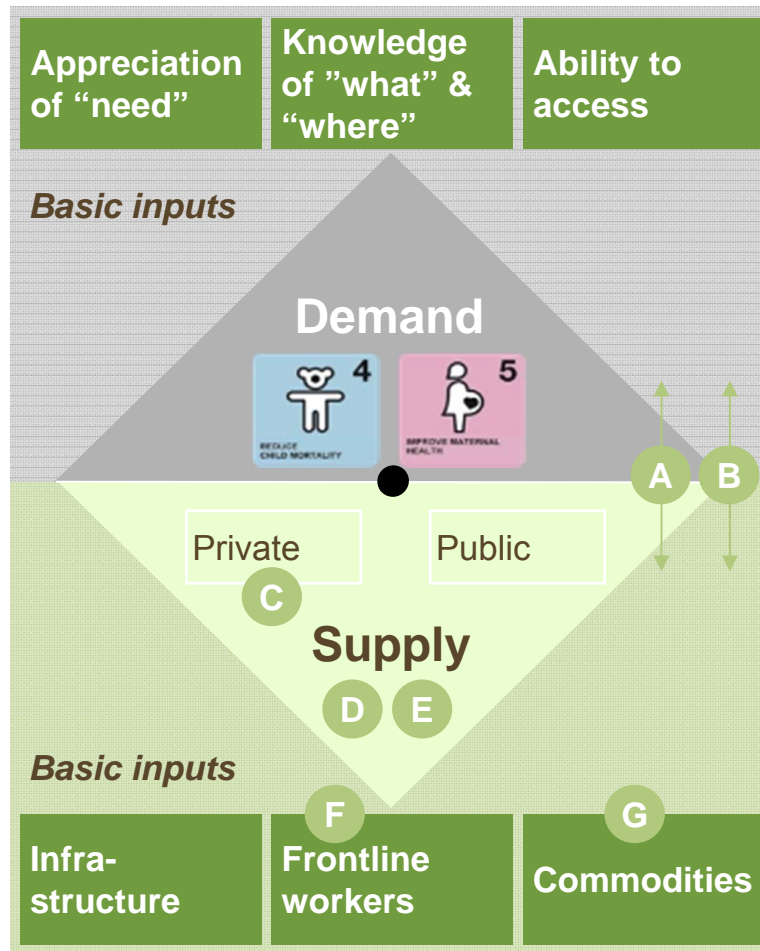
Source: UN Data, Liu et al. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000 (2012), The Lancet, Early Online Publication, Countdown countries; team analysis

3 Scaling-up and sustaining high impact interventions depends on strengthening both demand and supply



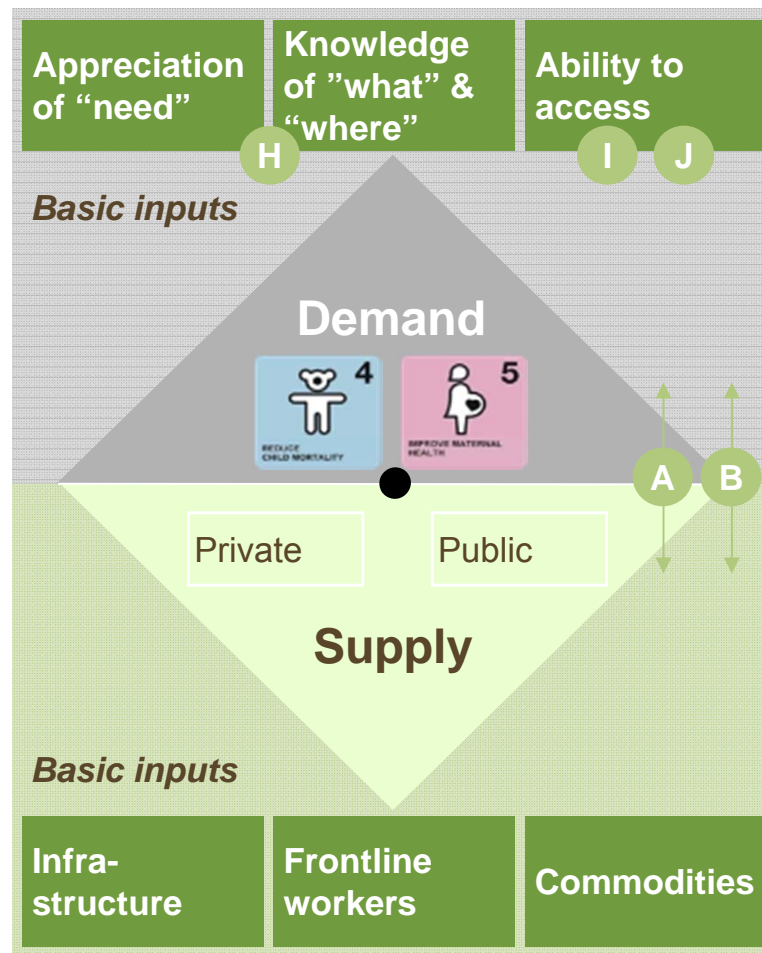
- In Malawi, a study found that roughly 50% of women not delivering in an institution, attributed the cause to demand constraints including transportation, cost and family influence
- And yet, despite the importance of demand-factors, partners in Malawi focus predominantly on supply side challenges

3 Supply side barriers include infrastructure, frontline health workers and commodities through both public, private, and NGO delivery systems



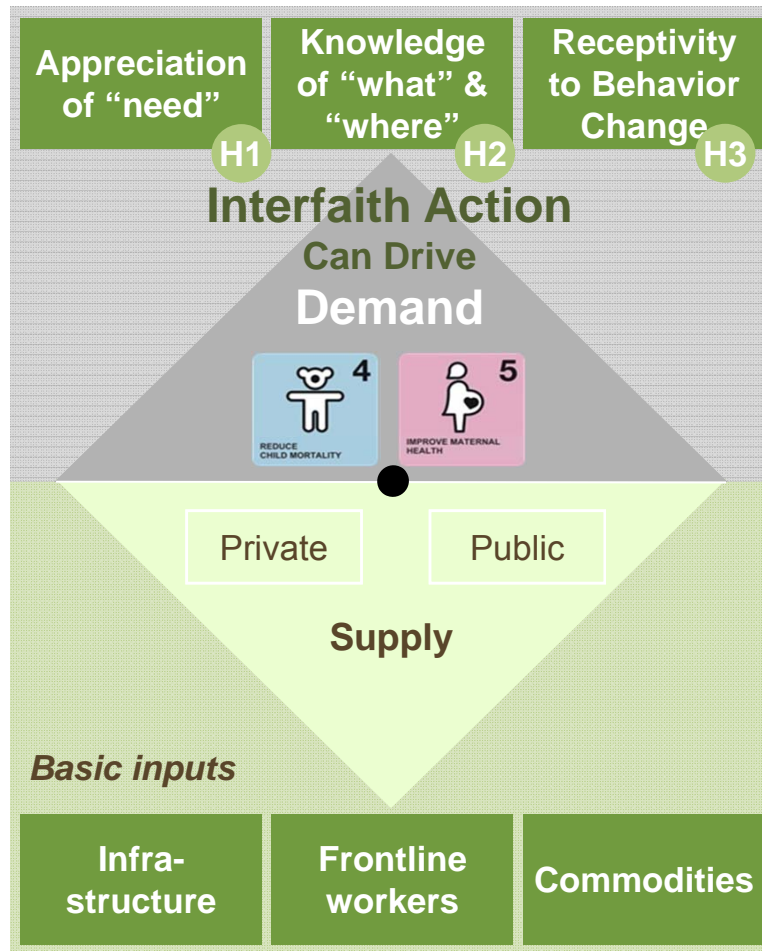
- A Ensure sufficiency of financial resources for family health
- B Integrate vertical programs and funding for family health
- C Include private sector in service provision
- D Improve management skills & capabilities
- E Improve supply-side performance e.g. Rwanda PBF aligned payment with validated payment of quality services
- F **Increase quantity of health workers and design of frontline health worker model:** Ethiopia and Bangladesh have expanded their front-line health workforce, shifting tasks and integrating service provision.
- G **Commodities**
 - The Commission on Life-saving Commodities identified 10 concrete recommendations to strengthen the marketing, distribution, management and monitoring of commodities.
 - SMS for Life Initiative, used simple tools to reduce stock outs from 79% to less than 26% in 3 Tanzanian districts

3 Increasing demand requires understanding and addressing the constraints as perceived by mother, family and community; countries are pioneering new approaches that are having an impact



- A** Ensure sufficiency of financial resources for family health
- B** Integrate vertical programs and funding for family health
- H** **Accelerate demand-side behavior change:** A community action group that gave voice to village women and demand deterrents resulted in large increases in coverage of antenatal care (71% vs. 54% average), post-natal check-up (79% vs 18-54% average); and with over 64% of women receiving pre-delivery counseling on family planning and 73% on PMTCT
- I** **Decrease demand-side financial barriers to access:** Innovative Indian cash transfer program to women who deliver in institutions and to community (JSY) health workers that help identify and support pregnant women resulted in reduced maternal and neonatal deaths
- J** **Decrease geographic barriers to access & service delivery:** Bangladesh achieved a 4.1% annual rate of reduction for neonatal mortality by focusing on community based care, training health workers, upgrading facilities for emergency obstetric care and exploring new home-based strategies for communities with weak systems

3 Faith and civil leaders can generate appropriate demand and drive positive behavior change



Demand meets supply at the community level

- H1 Drive demand for products/services:** Faith and civil leaders – when equipped with the right training and tools – can empower individuals to make better-informed behavioral decisions and support increased utilization of commodities and services.
- H2 Connect families to local resources:** Faith and civil leaders are trusted, influential, present in even the most rural areas, and positioned to deliver information and encourage mothers and children to utilize health commodities and resources provided by ministries of health, aid agencies and the development community.
- H3 Change behavior at home (a cornerstone of sustained success):** Everyday behaviors can dramatically impact individual and community health and well-being, such as washing hands with soap, breast-feeding babies, or making healthier food choices when they are available.

3 The Commission for Live Saving Commodities has created a strong set of recommendations with potential for real impact on child health

Improved markets

1. Shape global markets for optimal pricing and supply of effective products through innovative financing and procurement mechanisms and enhanced product selection.
2. Shape local delivery markets by changing the practices of health providers and incentivizing businesses to increase distribution and promotion of the products.
3. Reward performance on essential health commodities through catalytic financing that provides financial and non-financial rewards to countries .

Quality

4. Strengthen quality through inclusion of commodities in the Expert Review Panel (ERP) and Prequalification processes. Support at least three committed manufacturers per commodity to develop, manufacture and market affordable products of assured quality.
5. Improve regulation efficiency by countries standardizing registration requirements and streamlining assessment procedures .

Improved national delivery

6. Improve supply and awareness: countries establish mechanisms to regularly review, adapt and/or adopt state-of-the-art practices in mobile Health and electronic Logistics Management Information Systems.
7. Improve demand and awareness: country stakeholders review best practices in social and behavior change communication and develop plans to scale-up proven approaches for creating appropriate demand and promoting safe use of commodities.
8. Reaching women and children: governments undertake reviews of barriers women and children face in accessing services and commodities, and propose financial mechanisms (i.e. user fee waivers, cash transfers, insurance and voucher schemes) and adapted regulatory mechanisms to overcome barriers.
9. Performance and accountability: countries have in place mechanisms to review and use state-of-the-art practices in health provider performance and accountability mechanisms, including performance-based financing and new checklist tools.

Improved integration of the private sector and consumer needs

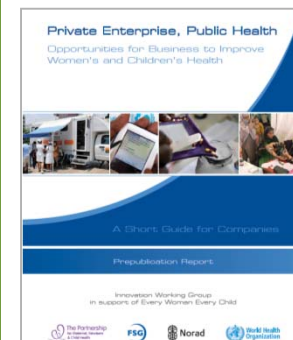
10. Product innovation: develop an incentive mechanisms to support regular consumer marketing research and development to optimize formulation, improve packaging, enhance delivery devices, and facilitate rapid regulatory approval of commodities and ease of use.

- Integrate into the child survival planning globally and in countries
- Begin and over-see implementation of recommendations

3 Private sector can help address gaps across health systems

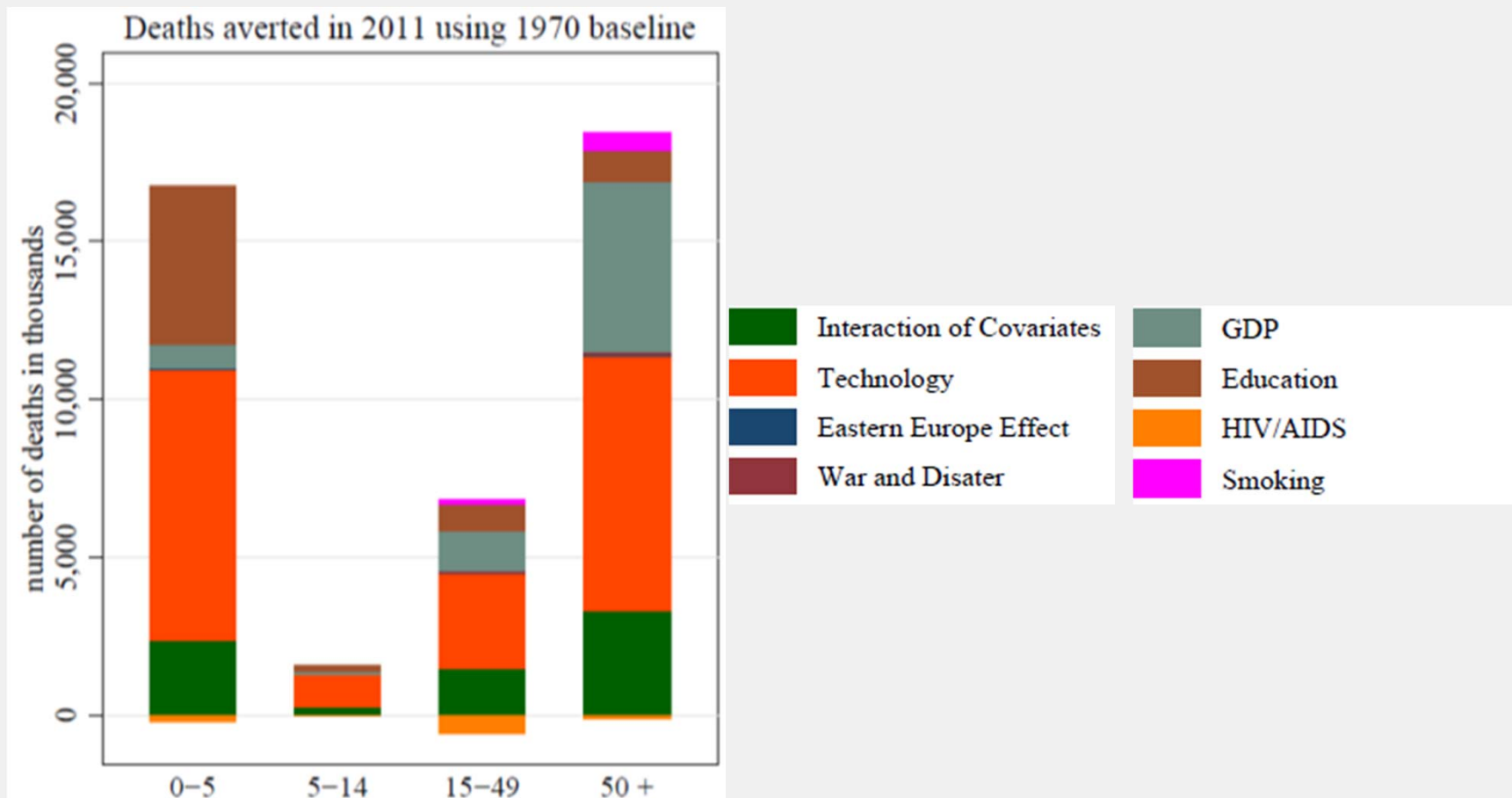
ILLUSTRATIVE EXAMPLES

	Pharmaceuticals	Medical Devices	Digital Technologies	Financial Services	Media, Comm.s & Entertainment
Health Products & Services	<ul style="list-style-type: none"> New or adapted products 	<ul style="list-style-type: none"> New or adapted products 	<i>Not a core competency</i>	<i>Not a core competency</i>	<i>Not a core competency</i>
Delivery Systems & Infrastructure	<ul style="list-style-type: none"> Reconfigured value chains that reach poorer patients 	<ul style="list-style-type: none"> Reconfigured value chains that reach poorer patients 	Technologies for: <ul style="list-style-type: none"> Dissemination of health information Financial services Capture and transfer of patient data Stock management and tracking 	<i>Not a core competency</i>	<i>Not a core competency</i>
Enabling Environment	<ul style="list-style-type: none"> Training health workers to deliver products Support for community health education Input to standards of care / treatment guidelines 	<ul style="list-style-type: none"> Training for health workers and laboratory staff; Screening campaigns; Input to regulatory frameworks; Guidelines for effective diagnosis 	Technologies to: <ul style="list-style-type: none"> Support health worker training Help decision makers generate & analyze data, Disseminate public health information 	<ul style="list-style-type: none"> Health insurance / payment services Infrastructure investment 	<ul style="list-style-type: none"> Behavior change & health education messaging Content development & provision Resource mobilization / advocacy

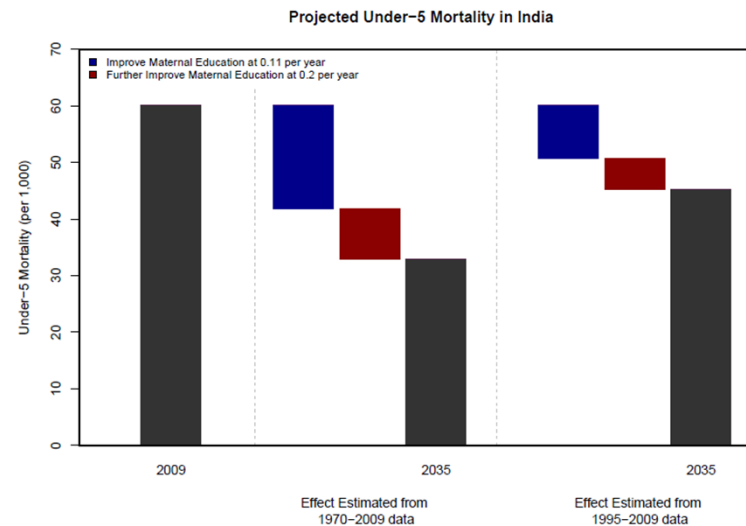
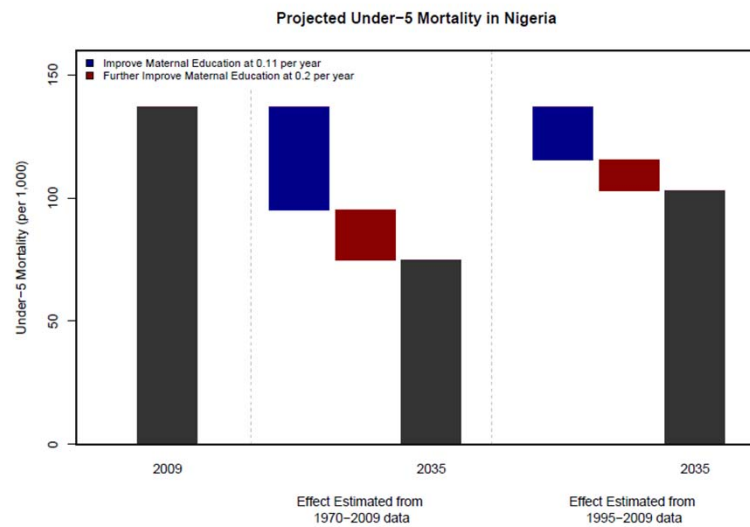
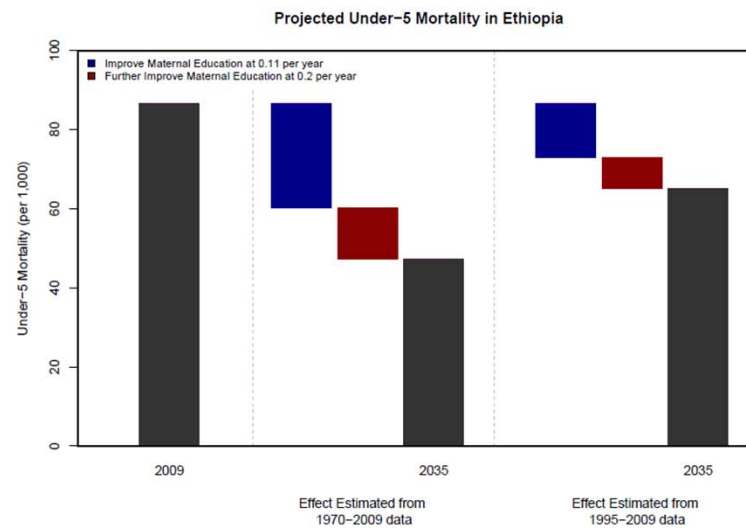
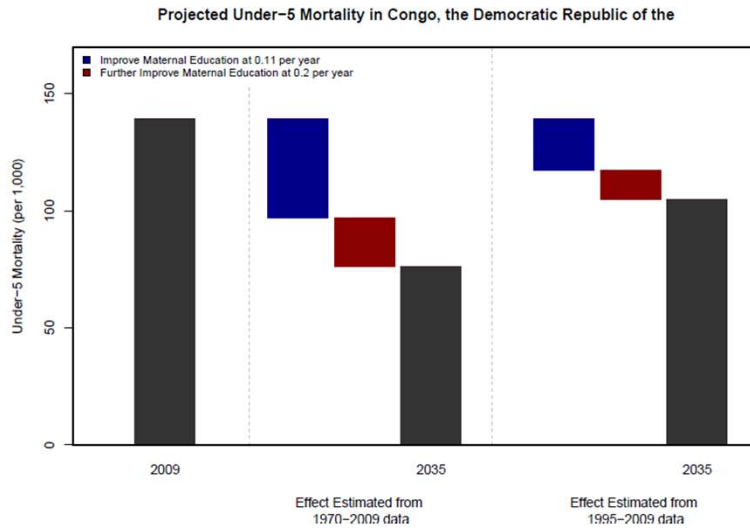


4 Broad determinants

- Improvements in girls/women's education has been shown to have a significant impact on U5MR
- In priority countries, education attainments have improved but if girls were given the same opportunities as boys, their attainments would double



4 The relationship of maternal education to under-five mortality appears to hold in the highest burden countries; increasing maternal education could have a very large impact on under-five mortality



Source: C Murray IHME



1

Executive summary

2

Vision for 2035

3

Where we are today

4

Strategic shifts: accelerating progress

5

Sustaining commitment

6

Case studies

5 Holding each other accountable for ending preventable child deaths

- Collectively **building the strategic shifts “into our DNA”** – globally, nationally, and locally – will ensure accountability
- A **common goal and metric**, e.g., ARR, is needed to drive change and measure progress
- Signing a **pledge** to acknowledge common vision and need to work to realizing it
- Increasing **transparency improves accountability**
 - In Uganda, a randomized control trial showed that **community monitoring** increased utilization and quality of services; most importantly it improved child survival, reducing U5MR by 33% in the focus area (see Cases section)
 - The ALMA Scorecard has provided African **Heads of State** with a compelling and understandable picture of how their country is performing relative to their neighbors
- As countries set child survival priorities, **allocations must be increasingly data driven and focus on the most impactful interventions**
 - As GDP grows in Middle and Low/Middle Income countries, governments are increasing allocations for health
 - Most governments struggle under pressure to meet the increasing health demands of their middle and upper income population versus investment in basic services that will have greater impact country-wide
 - Donor partners also need to focus on investments that will yield the greatest results in accelerating the reduction of child mortality

5 A Promise Renewed – a broad vision for sustaining the commitment to end preventable child deaths

A Promise Renewed

Working together to accelerate action on maternal, newborn and child survival by targeting investments in effective, life-saving interventions for children

National governments lead the effort by sharpening country action plans, with costed strategies for maternal and child survival, and identify five-year milestones for progress at the national and sub-national levels

Development partners pledge to align their support with government-led action plans and priorities

Private sector partners spur innovation and help identify new resources for child survival

Civil society promotes accountability and, through advocacy and action, supports the communities and families whose decisions influence prospects for maternal and child survival

5 A Promise Renewed: Committing to collective action on three fronts

1 Evidence-based country plans



- Sharpen government-led action plans with high-impact strategies to reach MDGs 4 and 5
- Track and sustain progress against 5 year milestones
- Align development support for child and maternal mortality with national strategies

2 Transparency and mutual accountability



- Build on existing mechanisms to monitor and report progress, nationally and globally
- Compile and disseminate annual global progress reports
- Promote accountability and transparency through regional and global forums

3 Global communication and social mobilization



- Mobilize the global child survival community around the common goal to end preventable child deaths
- Disseminate new data, modeling and lessons learned
- Celebrate national progress

5 Child survival scorecards are a tool to increase transparency and track results

ILLUSTRATIVE

Regional and National Child Survival scorecards will track progress against a common quantified indicator, e.g., ARR, and other key child survival indicators related to

Regional scorecard



- Build on the best practices of ALMA
- Track progress across countries against internationally agreed upon child survival indicators, e.g., UN Commission for Information and Accountability indicators

Country scorecards



Countries are developing national scorecards containing indicators that reflect country child survival priorities and that provide results at the national and sub-national levels

Metrics to ensure donor accountability will also be considered






5 A Promise Renewed will build on existing child survival efforts and processes

NOT EXHAUSTIVE

Key partners will have measurement, knowledge, and reporting tasks

Every Woman Every Child		<ul style="list-style-type: none"> Provide global leadership and a platform for child survival activities
UNICEF		<ul style="list-style-type: none"> Develop global scorecard indicators, tracking, and publication process and provide technical support for country scorecard development
PMNCH		<ul style="list-style-type: none"> Promote sharing of evidence and lessons learned from countries at regional workshops and through context-specific syntheses
Countdown 2015		<ul style="list-style-type: none"> Track and disseminate country progress against child survival, including coverage of essential health interventions
Commission on Information and Accountability for Women's Children and Health		<ul style="list-style-type: none"> Ensure transparency for allocation of commitments to women's and children's health
Commission on Life-saving Commodities		<ul style="list-style-type: none"> Build consensus on priority actions for increasing availability, affordability, accessibility and rational use of essential commodities for women's and children's health

Targets will be developed in coordination with existing timelines and goals

 	<p>2015 Millennium Development Goals 4 and 5 – maternal and child health</p>
  	<p>Coverage and U5MR targets, e.g., Global Fund will encourage countries to consider how Global Fund-resourced interventions accelerate child survival progress while incorporating the principles of the Global Fund</p>

5 Global and national actors are already building the strategic shifts into their DNA to create mutual accountability



Government
of Ethiopia



Government
of India



Government
of USA



- **Sharpened national plans** to accelerate progress toward Ending Preventable Child Death, setting **national targets**
 - Strengthened **country scorecards** with sub-national data to monitor progress
 - Identify and promote partnerships with country stakeholders
 - Use strategic voice to elevate child survival in regional and global forums
 - Ensure bilateral support **incorporates the strategic shifts** and aligns with revised national government plans
 - Build a **child survival results framework** into evaluations and procurement processes
 - **Allocate funding and technical support** using criteria tied to objective data on highest burdens – geographies, causes and populations
 - Incorporated into **strategic dialogues with leaders**
-
- **Support Promise Renewed, incorporate U5MR milestones** in program and partnership tracking and reporting
 - **Provide and support forums for leaders to assess progress and sharing lessons**
 - **Provide country support** to sharpen national plans

5 Incorporating strategic shifts into the “DNA” of national and global actors will make efforts more effective

NOT EXHAUSTIVE

Governments and health ministries



- Use new data and modeling to inform **performance dialogues on priorities and resource allocation**
- Develop **national scorecards** that underscore overall survival goals
- **Create transparency and visibility** into survival status and progress at sub-national levels
- **Identify and share successful country level innovations**

Civil society



- **Monitor and publish survival results** at the local, national, and global levels
- **Amplify efforts and voices around common overall child survival goal** – including education and awareness efforts

Private sector



- **Assess their programs** against national overall survival priorities
- **Develop PPPs** to address identified gaps in interventions and delivery strategies

Multilaterals/ bilaterals/ initiatives



- **Allocate funding and technical support using criteria** tied to objective data on highest burdens – geographies, causes and populations
- Alignment and emphasis on **overall metrics for progress** across child, neonate and maternal health
- **Unified support of potential country re-prioritization** based on objective data
- **Updated funding processes** to support multi-sector and multi-cause country priorities

Academic institutions



- **Re-calibrate research agenda** to highest burden topics

Private foundations



- Incorporate overall child survival metrics into **program design**
- **Evaluate choices** between initiatives using overall survival goals



1

Executive summary

2

Vision for 2035

3

Where we are today

4

Strategic shifts: accelerating progress

5

Sustaining commitment

6

Case studies

- Rwanda
- Tanzania
- Egypt
- Bangladesh
- India
- Tanzania
- Ethiopia
- Nepal
- Uganda
- Colombia

Rwanda systematically prioritized its high- burden diseases to accelerate decline in child mortality; from 2005 to 2010 the U5MR fell by almost half, with an ARR of almost 13%



	Description	Impact						
2001-2002	Commitment made to introduce community health workers dedicated to child health to address the top three causes of U5 mortality—malaria, pneumonia, diarrhea —each of which can be addressed by community-based health interventions	~ 60k child health CHWs trained between 2001 and 2012; goal is to have 2 per village						
2005	Malaria identified as the number 1 cause of U5M. Government focuses efforts by scaling up community-based delivery of ACT and long-lasting insecticide treated bed nets as well as targeted indoor residual spraying in high prevalence areas	<p>U5M decline Deaths per 1000 live births</p> <table border="1"> <tr> <th>Year</th> <th>U5M (Deaths per 1000 live births)</th> </tr> <tr> <td>2005</td> <td>151</td> </tr> <tr> <td>2010</td> <td>76</td> </tr> </table> <p>ARR 12.9%</p>	Year	U5M (Deaths per 1000 live births)	2005	151	2010	76
Year	U5M (Deaths per 1000 live births)							
2005	151							
2010	76							
2009	Pneumonia identified as next priority. According to the DHS Rwanda has seen a significant reduction in ARI from 17% in 2005 to 4% in 2010. Secured pneumococcal vaccine for national distribution and trained CHWs on rapid diagnostics to distinguish malaria from pneumonia , and on case-management of pneumonia with amoxicillin and zinc supplements							
2012 and beyond	Diarrhea and neonatal mortality identified as next priorities. Negotiated funding for rotavirus vaccine distribution. Implemented integrated management of newborn and childhood illness at the facility/community level. Introduced new vaccines.							

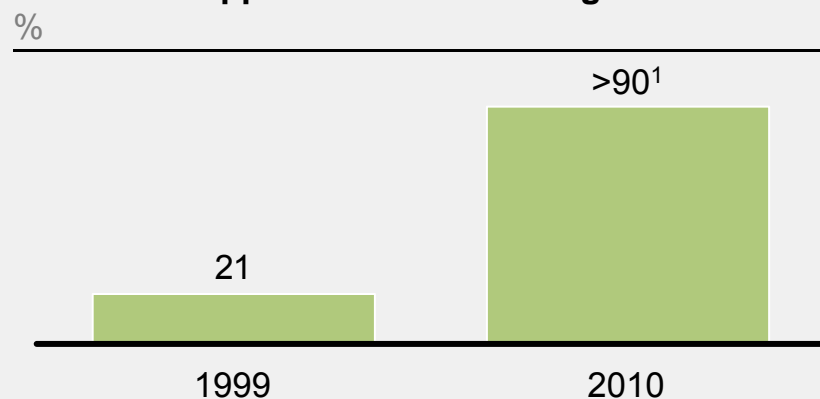
By making it a priority, Tanzania increased Vitamin A use by 14% - 15% per year until it reached 90% - 99% coverage



Tanzania's early efforts on Vitamin A supplementation (VAS) have contributed to significant declines in child mortality

- In 1997 Tanzania integrated VAS into its immunization program to expand national coverage to children below 2 years
- In 2005, Tanzania began intensifying efforts to make twice yearly VAS a priority for all children aged 6-59 months.
- Recognizing the important impact of this program, district authorities across Tanzania now routinely include VAS within their annual plans and budgets

Vitamin A supplementation coverage rate

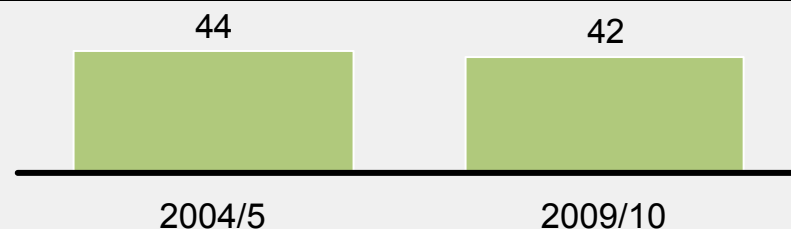


¹ SOWC records coverage rate of 99% for 2010; USAID reports >90%

Tanzania recently launched a cross sector nutrition strategy to accelerate slow progress on under-nutrition

Stunted children under five

Percentage



Acknowledging the high burden of stunting, President Kikwete has elevated nutrition as a top priority for economic growth and development:

- **National vision: child stunting rates < 22% by 2015**
- Created national budget line for nutrition in 2012
- Creating PM's Office-led Steering Committee on nutrition to engage all sectors' roles
- Currently finalizing fortification standards for oil, wheat and maize flour
- Creating a new cadre of Nutrition Officers in all districts
- Backed by the global SUN movement and in-country partners, Tanzania is moving swiftly to translate the high level commitments into action at all levels

Egypt – national attention to a 1992 survey on maternal and child mortality brought concerted action – and a 7% ARR sustained over 20 years



Insights on addressing neonatal mortality rates

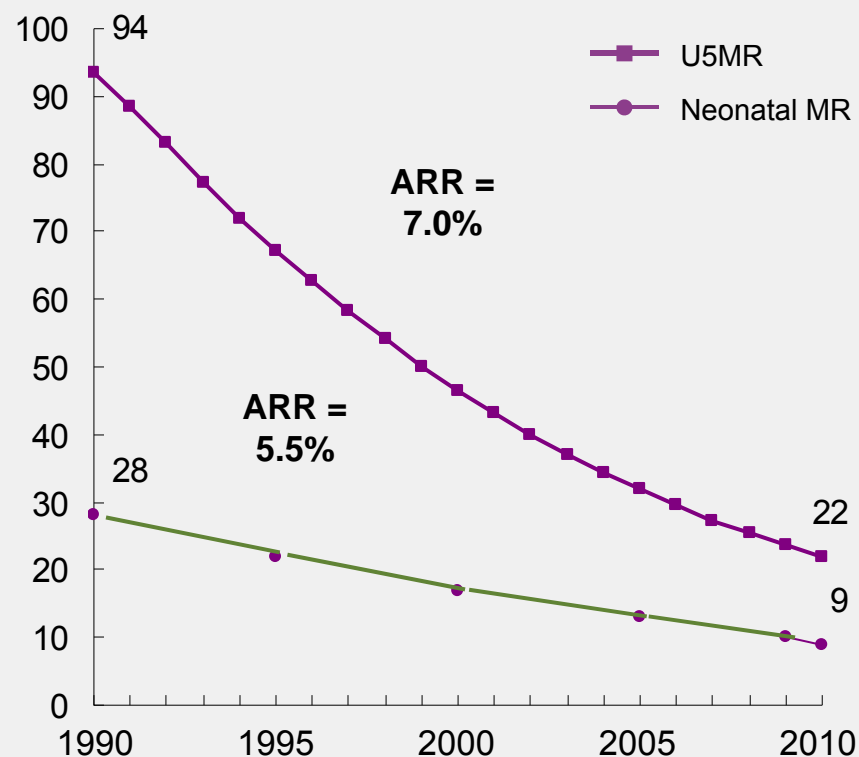
Recognize the magnitude of neonatal mortality and commit to addressing full continuum of care

Supply: Progress on neonatal survival requires the expansion of facility-based care, but short-term gains can be made by improving access to other community-based services

Demand: Increasing utilization of skilled birth attendants may involve incentives for mothers and efforts to overcome cultural barriers to in-facility deliveries

Mortality rates

Deaths per thousand live births



Egypt: 1990-2010 U5MR ARR 7%; overall decline 77%

Key actions

Identification of maternal and neonatal health as a priority: 1992 survey on maternal mortality brought national attention to the need for MNCH services.

Acting on data: In response to 1992 survey, the country launches two programs: Safe Motherhood (1992) and Healthy Mother Healthy Child (1993) to scale up MNCH services.

Impact

- MMR halved after the survey and initiation of MNCH programs between 1992 and 2000
- Neonatal mortality rate reduced steadily at an ARR of 5.5% from 1990 to 2010

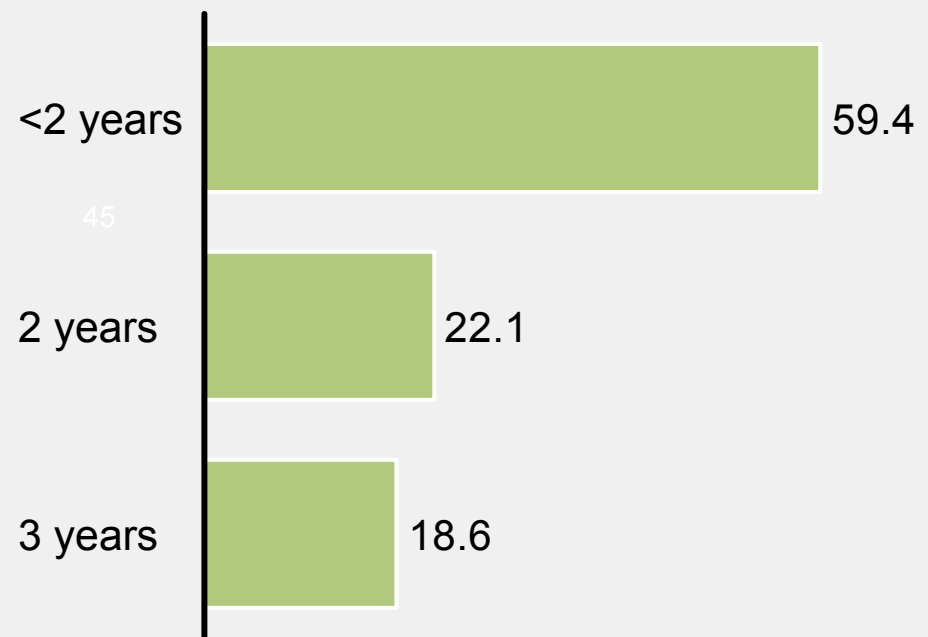
Family Planning Legacy in Egypt



Family Planning investments in Egypt prevented “millions of infant/child deaths and high-risk births, ...and saved ...thousands of mothers’ lives.”

- FP investments between 1980 and 2008 resulted in:
 - 3.8 million fewer infant deaths
 - 7 million fewer childhood deaths
 - Fewer maternal deaths, with 18,000 women’s lives saved
 - A dramatic decline in the total fertility rate -- 5.6 (1976) to 3.0 (2008)
 - A significant increase in the contraceptive prevalence rate (all methods) -- 19% (1976) to 60% (2008)

Egypt: Infant mortality rate by previous birth interval, 2008



Bangladesh showed that home care can be effective in reducing neonatal mortality – interventions brought a 4.1% ARR from 2000 to 2010



Description

Impact

- Addressing supply-side issues
- In 2000 Bangladesh invested in **training more than 6000 community-based skilled birth attendants** and upgraded more than **100 health facilities to handle emergency obstetric care**.
- Between 2001 and 2010 deliveries managed by **skilled birth attendants increased from 12% of deliveries to 27%**.
- A seminal study on home-based strategies for newborn care in Bangladesh demonstrates that **home-care is effective in reducing neonatal mortality** in communities where health systems are weak and where there is high neonatal mortality, helping to define Bangladesh's approach to extending coverage

- Bangladesh achieves a **4.1% ARR for neonatal mortality** from 2000 to 2010

Source: Lancet 2008 Baqui et al. Effect of community-based newborn-care intervention package implemented through two service-delivery strategies in Sylhet district, Bangladesh: a cluster-randomised controlled trial Bangladesh Maternal Mortality and Healthcare Survey 2010

In India, conditional cash transfer to promote safe deliveries decreased perinatal and neonatal mortality

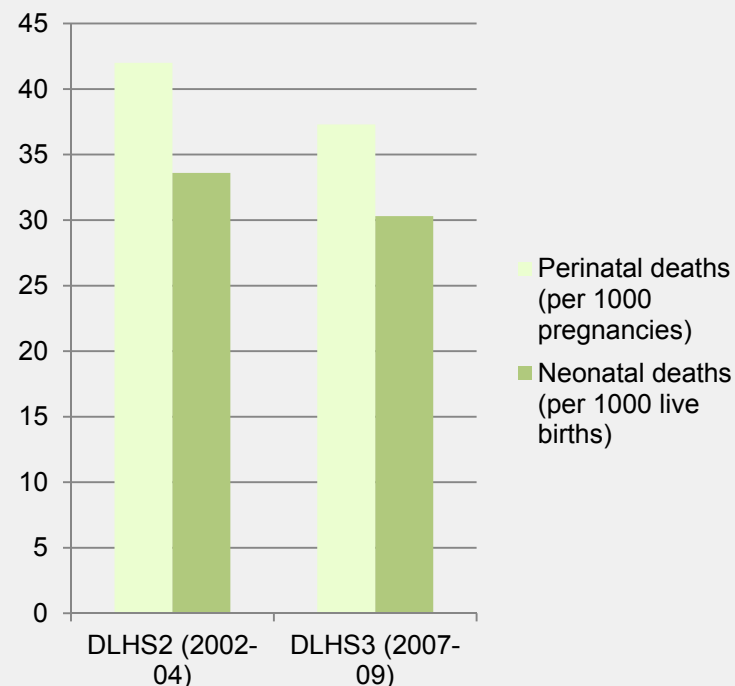


Description

- **Janani Suraksha Yojana (JSY)** a conditional cash transfer flagship program under the 'National Rural Health Mission' launched in 2005.
- JSY covers ~10 million pregnant women with a budget of \$342 million.
- JSY encourages women to **deliver at facilities (govt./private)**
- **Community health workers (ASHAs)** identify pregnant women and encourage them to use antenatal services, delivery at facility, and postnatal care.
- Payment is made to the ASHAs and pregnant women.
- Significant increase in antenatal care & facility births.
- **Poorest and least-educated women underutilize** antenatal care and facility-based deliveries, indicating a need to improve program outreach to the poorest

Impact

- JSY payment was associated with a **reduction of perinatal and neonatal mortality**: 4.1 perinatal deaths per 1000 pregnancies and 2.4 neonatal deaths per 1000 live births

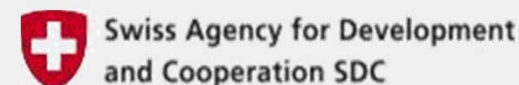


SMS for Life Initiative reduced stockouts of anti-malarial drugs from 79% to 26% in Tanzania – now being expanded to other drugs, other countries



SMS for Life program elements:

- Uses **mobile phones, SMS messages, and electronic mapping** to track weekly stock levels of injectable quinine and artemether-lumefantrine at public health facilities
- **Weekly stock requests sent by SMS to a healthcare worker at each facility**; stock messages sent back at no cost to the healthcare worker
- **District managers** access data on stock levels via secure website



Barriers addressed:

- **Reduces high level of stock-outs** at rural health facilities
- Provides **visibility to district management on the medicine stock levels** in their facilities
- Improves **ability to forecast demand for malaria medicines**

Preliminary impact:

- Stock-outs **reduced from 79% to < 26%** in three Tanzania districts
- 5000 facilities in Tanzania trained and tracking on a weekly basis
- Additional medicines, e.g., for tuberculosis, are now being tracked
- Expanding to other countries (e.g., Kenya and DRC)

Source: UN Commission on Life-Saving Commodities for Women and Children; Barrington et al SMS for Life: a pilot project to improve anti-malarial drug supply management in rural Tanzania using standard technology. Malaria Journal 2010 9:298.

Community-based delivery mechanisms in Ethiopia reached previously unreached areas – impact on stunting, contraception use and a 5.4% ARR on under-5 mortality from 2005 - 2011



Insights on the scale sustainability & accountability that can be achieved through community ownership

Scale: Extending coverage of services to large populations and remote areas is possible when community-based practitioners link communities with health facilities

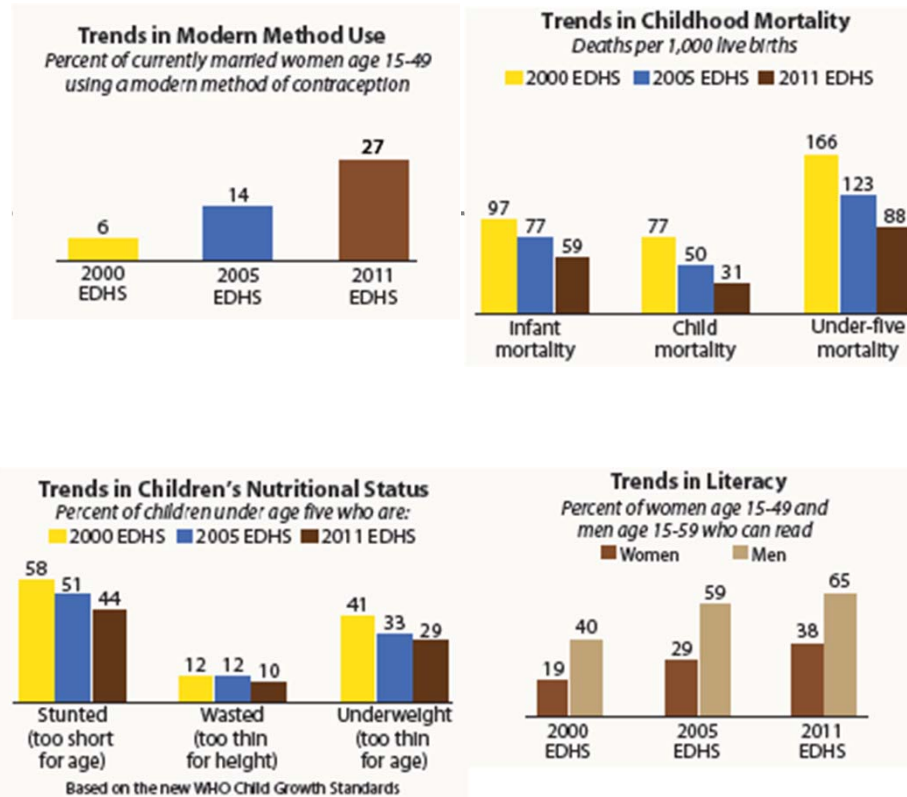
Sustainability: Community participation and ownership is key to propagating and sustaining positive health behavior changes

Accountability: Engagement of community-based health workers in local governance and decision-making processes reinforces accountability at all levels

Ethiopia: 2005 -2011 U5MR Annual Reduction Rate 5.4% Demonstrated impact: 2005 – 2011

Health Extension Program (HEP) Launched in 2004, Ethiopia's HEP has trained and deployed over 34,000 government-salaried female Health Extension Workers (HEWs) to promote positive health behaviors at the household and village levels throughout the country. After a year of training, HEWs, working in pairs out of the 15,000 village Health Posts built by their communities, provide health education, through regular house calls and 'community conversations' focusing on water and sanitation, child health, nutrition and family planning. Using an innovative 'model family' approach, HEWs are empowering families to become 'producers of their own health' and to lead others by example. HEWs also give immunizations and provide family planning services at the community level. As members of their local government cabinets, HEWs take part in key decision-making and are accountable to their communities and the government for improved health and nutrition.

Since its inception, HEP's scope has expanded to include curative components community case management of severe acute malnutrition, diarrhea, pneumonia, and malaria. To support HEWs, the Government is also investing in a massive program to construct 3,200 Health Centers and accelerating training of mid-level professionals, including Health Officers and midwives.



Nepal achieved over 5 % annual improvement in under-5 mortality using community-based healthcare delivery and local monitoring



Description

- **Female Community Health Volunteers** program was launched in 1988 to **widen the geographic scope of child and maternal health services to rural areas**
- After health service delivery was decentralized in 1999, data systems have been used to **track progress and inform decision making on a subnational level**
- In 2007 **free health care is declared a constitutional right**, committing the government to provide health care to all regions of the country

Impact

- 1990-2010 U5MR ARR 5.1%

Nepal's goal is to provide universal coverage of services

Uganda used community scorecards to promote accountability – under-5 mortality decreased by a third vs controls, utilization increased, perception of quality increased



Insights on mutual accountability and transparency

Transparency and accountability can improve coverage of interventions and quality of service delivery

Community monitoring can offer a potent complement to top-down strategies when central enforcement mechanisms are weak

Data should be sufficiently granular and transparent to act on where services are delivered and for higher-level strategy

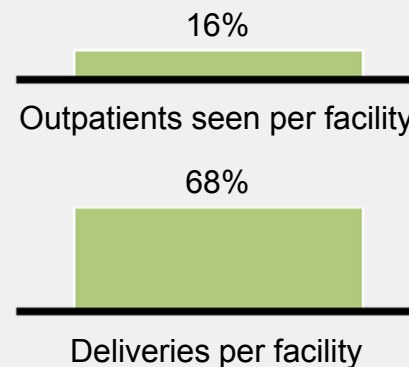
Community monitoring overcomes weaknesses in top-down accountability

- When centralized monitoring of health service delivery is weak there are **insufficient incentives for providers to perform well**
- This can lead to **extortion of fees** at the point of care, **embezzlement** of supplies, and worker **absenteeism**
- In such a context, a large project in Uganda (9 districts, 55,000 households) created a **community scorecard** that provides citizens with baseline information of the **status of service delivery** in absolute terms and relative to other providers
- This creates a social incentive for providers to perform well

A randomized control trial showed that community monitoring increased utilization and quality...

Impact on utilization

Percent improvement in utilization

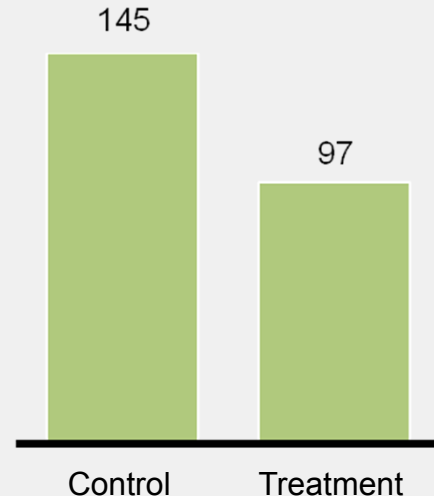


In addition, citizens' perception of service **quality improved**, citizen **engagement with service delivery** increased, and **awareness of entitlements** increased

...and improved child survival

U5MR after 1 year

Deaths per thousand live births



Guatemala: Scale-Up of voluntary family planning services showed a 3.6% annual increase in contraceptive prevalence sustained over 10 years and a 3.4% decrease in fertility over the same period



Guatemala in 2000

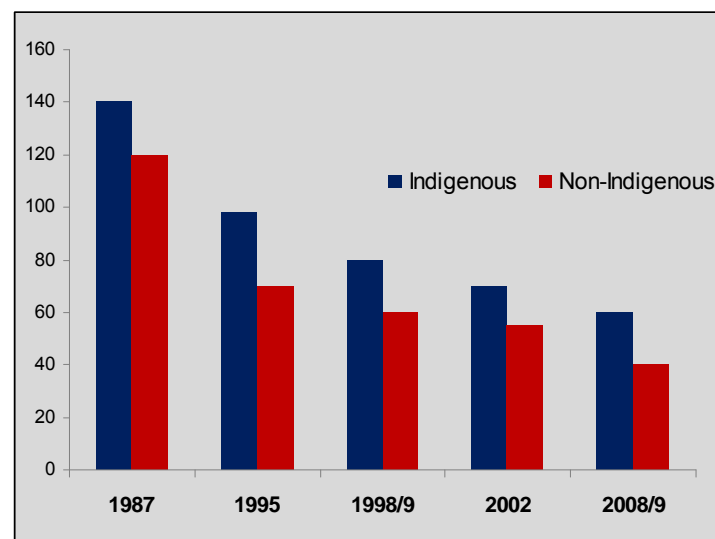
- Highest total fertility rate in Latin America
- Almost half of children were stunted
- USAID/Guatemala began working with the MoH and local organizations to inform women of contraceptive choices and the importance of spacing births.

Guatemala: National Family Planning Program Facilities Providing Family Planning Services (2011)



Results

- Under the National Reproductive Health Program – FP Services were expanded to over 2000 delivery points
- CPR increased from 38% (1998) to 54% (2008), faster than comparative changes in Central and South America (**annual growth rate = 3.6%**)
- TFR fell from 5.1(1998) to 3.6 (2008) (**annual rate of reduction = 3.4%**)
- By 2005, a nationwide poll indicated that 94% of Guatemalans believed that families with fewer children had a better life



Source: Frontlines, "Nutrition and Family Planning Intersect for a Healthier Guatemala," Judith Timyan, April/May 2011, and "USAID's Legacy of Family Planning Technical Assistance to the Guatemalan Public Health Sector," Health Care Improvement Project, January 2012.