in focus

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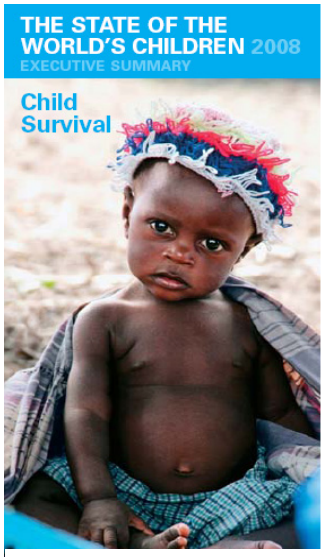
GLOBAL CHILD HEALTH IMPROVES, MAJOR CHALLENGES LIE AHEAD

UNICEF Reports Progress, Cites Challenges to Curtailing Global Child Mortality



A baby at a camp for displaced people near the town of Caia in Sofala Province in Mozambique stares out from the cover of UNICEF's 2008 report *The State of the World's Children.*

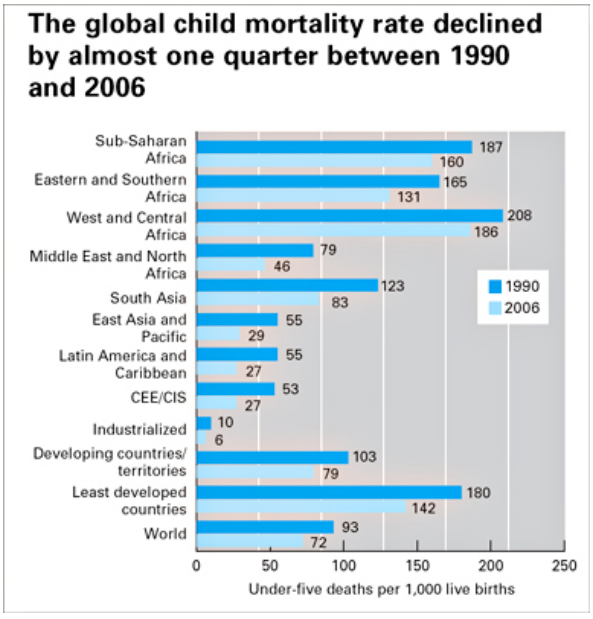
In 1960, roughly 20 million newborns did not live to see their fifth birthday; by 2006, the annual number of child deaths globally fell below 10 million, to 9.7 million, for the first time since records began.

This is significant and encouraging news, yet every day on average, more than 26,000 children under the age of five still die around the world, mostly from preventable causes. Nearly all of them live in the developing world or, more precisely, in 60 developing countries. More than one-third of these children die during the first month of life, usually at home and without access to essential health services and basic commodities that might save their lives.

Born of large-scale concern, UNICEF's landmark report, *The State of the World's Children 2008,* examines the status of child survival and primary health care for children across the globe, with a strong emphasis on trends in child mortality. This seminal report by the United Nations Children's Fund (UNICEF) outlines the results of long-term partnerships developed in response to the child survival revolution, reviews the experiences and approaches to child survival and health of recent decades, and appraises the lessons from failures and successes in child survival over the past century.

The centerpiece of the report examines several of the most promising approaches – community partnerships, the continuum of care framework and health-system strengthening for outcomes – to reach those mothers, newborns and children who are currently excluded from essential interventions. By highlighting examples from countries and districts where these have been successful and exploring the main challenges to their expansion, this report offers practical ways to jump-start progress.

The Current State of Child Survival, Mortality and Health



Data reproduced from: United Nations Children's Fund, *The State of the World's Children 2008, Child Survival,* UNICEF, New York, December 2007, pp 6.

The State of the World's Children 2008 documents

SUB-SAHARAN AFRICA

INDICATOR	REGION	WORLD
Demographic indicators		
Total population (2006)	748,886,000	6,577,236,000
Population under 18 (2006)	376,047,000	2,212,024,000
Population under 5 (2006)	125,254,000	625,781,000
Survival		
Life expectancy at birth (2006)	50	68
Neonatal mortality rate (under 28 days), per 1,000 live births (2000)	44	30
Infant mortality rate (under 1), per 1,000 live births (2006)	95	49
Under-5 mortality rate, per 1,000 live births (2006)	160	72
Under-5 mortality rate, average annual rate of reduction (1990-2006)	1.0	1.6
Maternal mortality ratio, per 100,000 live births (2005, adjusted)	920	400
Health and nutrition		
Percentage of infants with low birthweight (1999-2006*)	14	15
Percentage of under-5s who are moderately or severely underweight (2000-2006*)	28	25
Percentage of population using improved drinking-water sources (2004)	55	83
Urban	81	95
Rural	41	73
Percentage of population using adequate sanitation facilities (2004)	37	59
Percentage of 1-year-old children immunized (2006) against:		
Tuberculosis (BCG)	82	87
Diphtheria/pertussis/tetanus (DPT1)	83	89
Diphtheria/pertussis/tetanus (DPT3)	72	79
Polio (polio3)	74	80
Measles	72	80
Hepatitis B (hepB3)	48	60
Haemophilus influenzae type b (Hib3)	24	22
Education		
Percentage of primary school entrants reaching grade 5 (administrative data; 2000-2006*)	70	78 **
Net primary school attendance ratio (2000-2006*)		
Male	64	80
Female	60	78
Net secondary school attendance ratio (2000-2006*)		
Male	25	50 **
Female	22	47 **
Adult literacy rate (2000-2005*)	58	78

INDICATOR	REGION	WORLD
Economic indicators		
GNI per capita (US$, 2006)	851	7,406
Percentage of population living on less than $1 a day (1995-2005*)	43	19
Percentage share of central government expenditure (1995-2005*) allocated to:		
Health	-	14
Education	-	5
Defence	-	11
Percentage share of household income (1995-2004*):		
Lowest 40 per cent	13	20
Highest 20 per cent	55	42
HIV/AIDS		
Adult prevalence rate (15-49 years, end 2005)	6.1	1.0
Estimated number of people (all ages) living with HIV (2005)	24,500,000	38,600,000
Estimated number of children (0-14 years) living with HIV (2005)	2,000,000	2,300,000
Estimated number of children (0-17 years) orphaned by AIDS (2005)	12,000,000	15,200,000
Child protection		
Birth registration◊ (1999-2005*)	34	-
Urban	52	-
Rural	28	-
Child marriage (1987-2005*)	40	-
Urban	24	-
Rural	47	-
Child labour (5-14 years, 1999-2005*)	35	-
Male	36	-
Female	34	-
Women		
Adult literacy parity rate (females as a percentage of males, 2000-2006*)	72	86
Antenatal care coverage (percentage, 2000-2006*)	69	75
Skilled attendant at delivery (percentage, 2000-2006*)	43	63
Lifetime risk of maternal death (2005)	1 in: 22	92

NOTES:

* Data refer to the most recent year available during the period specified.

** Excludes China.

- Data not available.

◊ The global and regional estimates for birth registration included in this table are based on the subset of countries for which data are available for the period 1999-2006. Global and regional estimates for a wider set of countries are available for the period 1997-2006 and can be found at www.childinfo.org/areas/birthregistration.

Data reproduced from: United Nations Children's Fund, *The State of the World's Children 2008, Child Survival*, Executive Summary, UNICEF, New York, December 2007, pp 20-21.

impressive progress since 1990 in improving the survival rates and health of children, even in some of the world's poorest countries. In fact, the global child mortality rate declined by almost 25 percent between 1990 and 2006 (the most recent year for which firm estimates are available). Meanwhile, increased coverage of measles vaccinations and follow-up campaigns, for example, contributed to a 60 percent fall in global measles deaths and a 75 percent reduction in measles mortality in sub-Saharan Africa between 1999 and 2005. Recent years have seen important and, in some cases, remarkable advances in child survival, despite considerable impediments, most notably the onslaught of AIDS in Eastern and Southern Africa, and internecine conflict in many high-mortality countries.

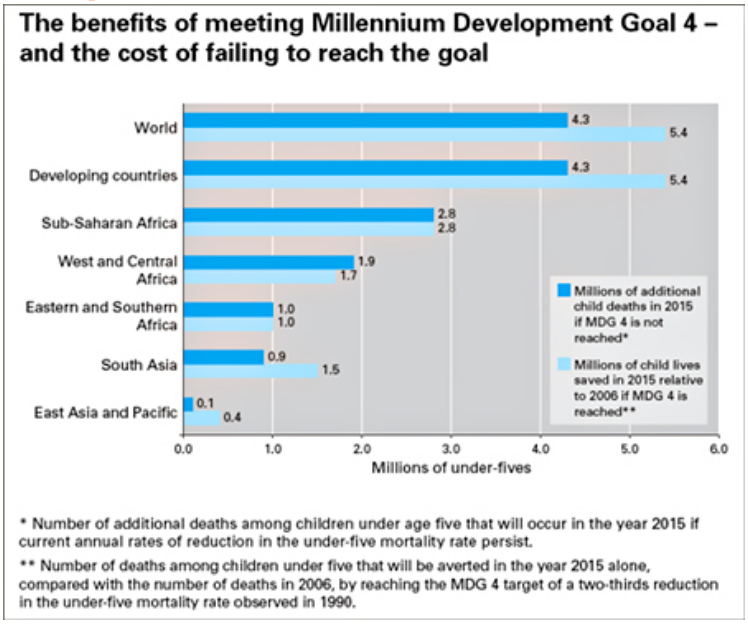
Looking at the overall picture, in 2006, the global child mortality rate was estimated at 72 deaths per 1,000 live births, 23 percent lower than the 1990 level. Child mortality rates have been roughly halved in East Asia and the Pacific; Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS); and Latin America and the Caribbean – bringing the under-five mortality rate for each of these regions below 30 per 1,000 live births in 2006. (The average rate of industrialized countries in 2006 was six deaths per 1,000 live births.)

The Middle East and North Africa region also has seen steady progress in reducing rates. South Asia is making headway as well, although it still has the second highest number of child deaths, accounting for 32 percent of global under-five mortality rates, with undernutrition a major contributing factor.

Sub-Saharan Africa remains the most troubling geographic area. It has the highest rate of child mortality by far: On

average, one in every six children there dies before age five. In addition, the region as a whole has shown the least progress, managing to reduce the burden of child mortality by only 14 percent between 1990 and 2006, with a number of countries in the region registering increases in under-five mortality rates. In 2006, 49 percent of all deaths of children under age five occurred in sub-Saharan Africa, despite the fact that only 22 percent of the world's children are born there.

Reducing Under-Five Mortality—Achieving Millennium Development Goal 4



Data reproduced from: United Nations Children's Fund, *The State of the World's Children 2008, Child Survival*, UNICEF, New York, December 2007, pp 2.

The current focus of the development community in relation to child survival is Millennium Development Goal (MDG) 4, which aims to reduce the global rate of under-five mortality by two-thirds between 1990 and 2015. At present, four regions are on track to meet MDG 4: East Asia and the Pacific; Latin America and the Caribbean; CEE/CIS; and the industrialized countries/territories. Despite recent progress, achieving this goal will require a reduction in the number of child deaths between 2008 and 2015 at a far faster rate than the world has managed since 1990. If current trends continue, 4.3 million child deaths will occur in 2015 that could have been averted had MDG 4 been met.

On a country-by-country basis, UNICEF estimates that 129 nations are on track. Some of these have already met the 2015 goal for reducing child mortality, while others are poised to do so. Approximately 18 percent, or 35 countries, are making progress towards achieving MDG 4, but at a rate that is insufficient to meet it in full and on time.

Of most concern are the 27 countries that have registered scant progress since 1990 or have an under-five mortality rate that is stagnant or higher than it was 18 years ago. Of the 46 countries in sub-Saharan Africa, for example, only Cape Verde, Eritrea and Seychelles are on track to meet MDG 4. The region as a whole only managed to reduce child mortality at an average annual rate of 1 percent from 1990 to 2006, and double-digit reductions will be needed during each of the remaining years if it is to meet MDG 4.

MDGs Prioritize Children

In addition to MDG 4, curtailing child mortality especially requires reducing poverty and hunger (MDG 1), improving maternal health (MDG 5), combating HIV, AIDS, malaria and other major diseases (MDG 6), and improving water and sanitation (MDG 7).

Improving maternal and child nutrition is, in fact, a prerequisite for achieving MDG 4. Seemingly simple things like upping the developing world's consumption of iodized salt, making sure more infants are exclusively breastfed during their first six months of life, and ensuring a full, two-dose coverage of vitamin A supplementation worldwide would go a long way towards achieving this goal. Meanwhile, almost 40 percent of all under-five deaths occur during the first 28 days of life from complications, including poor maternal health and care. In fact, one in every four pregnant women in the developing world receives no antenatal care, according to the latest estimates for 2000–2006, and more than 40 percent give birth without the assistance of a skilled attendant. Each year, more than 500,000 women die in childbirth or from complications during pregnancy, a probable death sentence for their babies.

As if that's not punishment enough, half of the infants infected with HIV will die before age two; malaria accounts for 8 percent of deaths in children under five; and measles for another 4 percent. Worldwide, 2.3 million children under age 15 are living with HIV, mostly in sub-Saharan Africa, and 530,000 children were newly infected with the virus in 2006, mostly through mother-to-child transmission. And while the world as a whole is on track to meet the MDG target for safe water, insufficient progress towards improved sanitation is making it difficult to combat diarrhea, which currently kills almost 2 million children every year.

Setting Priorities to Achieve MDGs and Improve Child Survival

The key interventions needed to address the major causes of child deaths are well established and accepted. In fact, research reveals that only about 1 percent of deaths among children under five have unknown causes and that two-thirds of them are entirely preventable through basic, yet important, services and practices such as having skilled attendants involved in delivery and newborn care; hygiene promotion; adequate nutrition; micronutrient supplementation to boost immune systems; oral rehydration therapy and zinc to combat diarrheal disease; and antibiotics to fight pneumonia.

Although much has been achieved to date, implementing these and other solutions has proved far more arduous than

LEAST DEVELOPED COUNTRIES

INDICATOR	REGION	WORLD
Demographic indicators		
Total population (2006)	785,444,000	6,577,236,000
Population under 18 (2006)	376,727,000	2,212,024,000
Population under 5 (2006)	122,114,000	625,781,000
Survival		
Life expectancy at birth (2006)	55	68
Neonatal mortality rate (under 28 days), per 1,000 live births (2000)	43	30
Infant mortality rate (under 1), per 1,000 live births (2006)	90	49
Under-5 mortality rate, per 1,000 live births (2006)	142	72
Under-5 mortality rate, average annual rate of reduction (1990-2006)	1.5	1.6
Maternal mortality ratio, per 100,000 live births (2005, adjusted)	870	400
Health and nutrition		
Percentage of infants with low birthweight (1999-2006*)	17	15
Percentage of under-5s who are moderately or severely underweight (2000-2006*)	35	25
Percentage of population using improved drinking-water sources (2004)	59	83
Urban	79	95
Rural	51	73
Percentage of population using adequate sanitation facilities (2004)	36	59
Percentage of 1-year-old children immunized (2006) against:		
Tuberculosis (BCG)	85	87
Diphtheria/pertussis/tetanus (DPT1)	87	89
Diphtheria/pertussis/tetanus (DPT3)	77	79
Polio (polio3)	77	80
Measles	74	80
Hepatitis B (hepB3)	50	60
Haemophilus influenzae type b (Hib3)	17	22
Education		
Percentage of primary school entrants reaching grade 5 (administrative data; 2000-2006*)	67	78 **
Net primary school attendance ratio (2000-2006*)		
Male	65	80
Female	63	78
Net secondary school attendance ratio (2000-2006*)		
Male	26	50 **
Female	24	47 **
Adult literacy rate (2000-2005*)	55	78

INDICATOR	REGION	WORLD
Economic indicators		
GNI per capita (US$, 2006)	438	7,406
Percentage of population living on less than $1 a day (1995-2005*)	38	19
Percentage share of central government expenditure (1995-2005*) allocated to:		
Health	5	14
Education	14	5
Defence	14	11
Percentage share of household income (1995-2004*):		
Lowest 40 per cent	15	20
Highest 20 per cent	50	42
HIV/AIDS		
Adult prevalence rate (15-49 years, end 2005)	2.7	1.0
Estimated number of people (all ages) living with HIV (2005)	11,700,000	38,600,000
Estimated number of children (0-14 years) living with HIV (2005)	1,100,000	2,300,000
Estimated number of children (0-17 years) orphaned by AIDS (2005)	-	15,200,000
Child protection		
Birth registration◊ (1999-2006*)	30	-
Urban	43	-
Rural	24	-
Child marriage (1987-2006*)	49	-
Urban	37	-
Rural	57	-
Child labour (5-14 years, 1999-2006*)	29	-
Male	31	-
Female	28	-
Women		
Adult literacy parity rate (females as a percentage of males, 2000-2006*)	68	86
Antenatal care coverage (percentage, 2000-2006*)	61	75
Skilled attendant at delivery (percentage, 2000-2006*)	38	63
Lifetime risk of maternal death (2005)	1 in: 24	92

NOTES:

* Data refer to the most recent year available during the period specified.

** Excludes China.

- Data not available.

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Data reproduced from: United Nations Children's Fund, *The State of the World's Children 2008, Child Survival*, Executive Summary, UNICEF, New York, December 2007, pp 40-41.

experts predicted at the start of the child survival revolution, and the results have been more elusive. In response, the development community is increasingly coalescing around priorities, which could provide the impetus needed to implement these basic services and practices, and achieve the health-related MDGs. These priorities include:

- Focusing on 60 countries where the burden of child mortality is highest, and which in 2005 together accounted for 93 percent of all under-five deaths.

- Providing a continuum of care for mothers, newborns and children by packaging interventions for delivery at key points in the life cycle.

- Strengthening community partnerships and health systems.

Evolving Health-Care Systems and Practices

The main challenge to child survival no longer lies in determining the proximate causes of or solutions to child mortality, but in ensuring that the services and education required for these solutions reach the most marginalized countries and communities.

Effective scale-up requires that we learn from the lessons of recent decades – with a particular emphasis on strengthening integrated approaches to child health at the community level. The current dominant framework for integration is the Integrated Management of Childhood Illness (IMCI), the strategies of which more than 100 countries have adopted since their 1992 introduction and which aim to improve health worker performance, strengthen health systems, and enhance community and family practices. Meanwhile, the

A group of children at a community child centre in Malawi.

more recent Accelerated Child Survival and Development initiative concentrates on community-based promotion of family health, nutrition and hygiene practices; outreach efforts and campaigns to provide essential services and products; and facility-based delivery of an integrated minimum-care package. It now covers more than 16 million people in 11 countries that have high rates of under-five mortality and builds on the strengths of existing approaches, including IMCI and the Expanded Programme on Immunization, which launched in 1974 and has been the most successful public health program to date.

In pursuing effective scale-up, interventions must be provided –- and initiatives developed –- within a continuum of care that engages communities and households, as well as outreach and facility-based care. Health systems must be strengthened at all levels and expanded to support new initiatives, including community partnerships, and they must be backed by strong national and international leadership and commitment. In addition, the many institutions involved in maternal and child survival, health and nutrition must work together effectively.

The projected impact of achieving a high rate of coverage with a continuum of health care could be profound. In sub-Saharan Africa, for example, achieving a continuum of care that covered 90 percent of mothers and newborns could avert two-thirds of newborn deaths, saving 800,000 lives each year.

Strengthening Community Partnerships and Health Systems

Community partnerships and participation show great potential to improve health, nutrition and environmental conditions, especially in countries with low health-system capacity, and particularly for the most marginalized and the poorest populations. Experience shows that successful community partnerships are based on several common factors:

- *Cohesive, inclusive community organization and participation:* Programs that build on established structures within a community, are socially inclusive and include community members in the planning, evaluation and implementation are among the most successful in developing countries.

- *Support and incentives for community health workers:* As primary agents of community-based treatment, education and counseling, these individuals require acknowledgement and encouragement to prevent attrition, meet their obligations and sustain motivation.

- *Adequate program supervision and support:* Supervision is required to sustain community members' interest and motivation, and lower the risk of attrition; support includes logistics, supplies and equipment.

- *Effective referral systems to facility-based care:* Hospitals and clinics are essential complements to successful community partnerships, providing services that cannot be safely replicated elsewhere; district health systems also serve as a focal point for public health program coordination.

- *Cooperation and coordination with other programs and sectors:* An integrated approach to maternal, newborn and child health necessitates collaborative action between programs and sectors addressing health, nutrition, hygiene, major diseases and food security, as well as intersectoral collaboration to address transportation infrastructure and access to water and sanitation facilities.

- *Secure financing:* To be successful over the longer term, financing for community partnerships should address considerations of sustainability and equity, including such issues as cost-sharing and financial incentives for community health workers.

- *Integration with district and national programs and policies:* Consultative multi-stakeholder processes are needed to develop strategies and ensure that maternal and child survival feature prominently in national and decentralized plans and budgets, with clear goals and concrete benchmarks.

A UNICEF-supported community development motivator counsels new and expectant mothers during a meeting in a local early childhood development centre in a village on remote Car Nicobar Island in India's Union Territory of Andaman and Nicobar Islands.

There are numerous examples of successful community partnerships in primary health care for mothers and children in CEE/CIS; East Asia and the Pacific; Latin America and the Caribbean; the Middle East and North Africa; South Asia; and, increasingly, in sub-Saharan Africa. Some community-based health programs are small-scale, involving only a few thousand or even a few hundred people; other initiatives, such as the Brazilian community health workers network or the Lady Health Workers program in Pakistan, encompass thousands of workers covering millions of children and women. The challenge is to learn from these experiences, take the programs to scale and reach the millions whom the health system continues to pass by.

In addition, national leadership and ownership of community partnerships are essential to ensure sustainability and foster expansion. Governments have a critical role in developing and implementing policies to lower barriers to primary health care, improving the quality and efficiency of service providers, and increasing public accountability.

Based on the joint framework developed by leading international agencies, including the World Bank, the World Health Organization and UNICEF, *The State of the World's Children 2008* has identified five distinct yet related actions to building up health systems across developing countries and territories through programs, policies and partnerships during the coming decade:

Action I: Realign programs from disease-specific interventions to evidence-based, high-impact, integrated intervention packages to ensure a continuum of care.

Action II: Make maternal and child health a central tenet of integrated national planning processes for scaling up essential services.

Action III: Improve the quality and consistency of financing for health-system strengthening.

Action IV: Obtain national political commitment.

Action V: Create conditions for greater harmonization of global health programs and partnerships.

Uniting for Child Survival

For governments, donors, international agencies and global health partnerships, effective scale-up will require a new way of working in primary health care among the key stakeholders. The central theme of this paradigm is unity. Initiatives and partnerships directed towards improving aspects of maternal and child health abound and continue to proliferate, but they will require greater coherence and harmonization to meet the health-related Millennium Development Goals for mothers and children.

The MDGs represent our best hope to accelerate human progress. Achieving the goals will mean that the lives of around 30 million children and 2 million mothers will have been spared between 2005 and 2015. Meeting the objectives will also result in hundreds of millions of children, men and women being relieved of hunger, utilizing safe water and basic sanitation, obtaining an education, and enjoying the same economic advantages and political opportunities that are available to others. The MDGs may also foster more balanced population dynamics, since, when parents are convinced that their children will survive, they are more likely to have fewer children and provide better care to those they have – and countries can invest more in each child.

Although several regions and nations are lagging, the targets are all reachable in time if the political will, necessary resources and required strategies are put in place. Six pivotal actions urgently need a unified response:

•*Create a supportive environment for maternal, newborn and child survival and health* by ensuring that health systems and programs are rights-based – and by supporting peace, security, child protection, non-discrimination, gender equality and the empowerment of women.

•*Develop and strengthen the continuum of care across time and location.* The continuum must deliver essential services at key points during the life cycle of mothers and children. Strong links are also required between the household, the community, and quality outreach and clinical services at primary health facilities and district hospitals.

•*Scale up packages of essential services by strengthening health systems and community partnerships* through initiatives to train health workers, extend outreach services, overcome bottlenecks and exploit new technologies.

•*Expand the data, research and evidence base.* Although the evidence base on maternal and child health is being provided by a rich array of resources, there is still a demand for more rigorous data collection and dissemination, research and evaluation.

•*Leverage resources for mothers, newborns and children.* Donor assistance is rising, but not fast enough to meet the goals. National governments must also fulfill promises to boost health spending.

•*Make maternal, newborn and child survival a global imperative.*

Accelerating progress will necessitate positioning these objectives at the heart of the international agenda in the run-up to the 2015 deadline for the Millennium Development Goals. The challenge is to build on the progress achieved across the developing world, particularly during recent years, in preventive interventions delivered by outreach services.

The foundation for action – built on data, research and evaluation – is well established. The frameworks – community partnerships, the continuum of care and health-

system strengthening for outcomes – are well defined. In effect, the means are in our hands. It is now a question of will, urgency and action.

The State of the World's Children 2008 *is UNICEF's landmark report in the struggle to reduce childhood mortality. The above synopsis of the report includes excerpts, highlights and information on UNICEF's Millennium Development Goals, which were adopted by world leaders in 2000 and focus on children.*

Q&A with Dr. Peter Salama

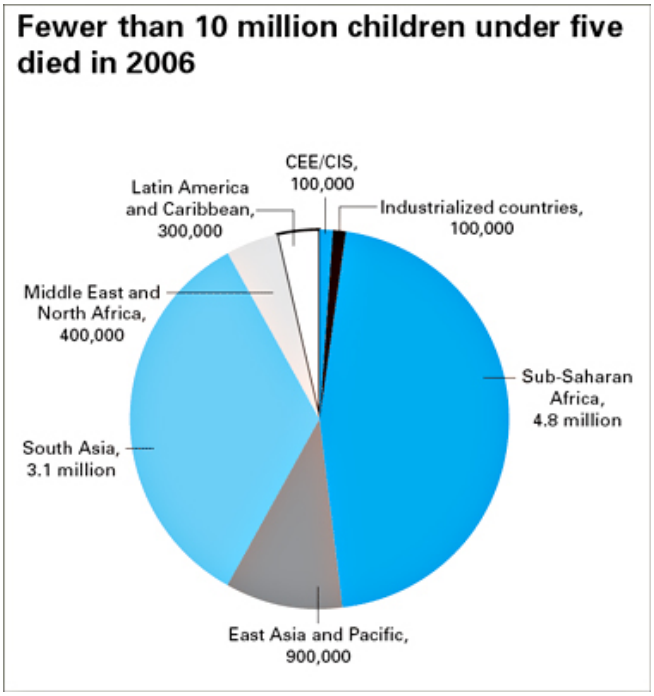
Dr. Peter Salama is Chief of Health, Associate Director, Programme Division, UNICEF, New York, N.Y.

1. UNICEF's *State of the World's Children 2008* report states that the latest data (i.e., from 2006) show a dramatic reduction in under-five annual global mortality from almost 13 million in 1990 to 9.7 million. What causes of childhood mortality have shown the greatest reductions and which the least?

In 2006, for the first time in recent history, the number of children dying before their fifth birthday fell below 10 million – an important milestone in child survival. Around 1960, an estimated 20 million children under age five were dying every year, highlighting an important long-term decline in the global number of child deaths.

While we know the overall estimates of child mortality, the cause-specific information is not that often actualized, and we are continuously working with different groups and institutions to refine this information. We do know from the recent data that coverage of many key child survival interventions has significantly increased, with rises in some basic practices and services, including vitamin A supplementation, the use of insecticide-treated nets to prevent malaria, immunization, and early and exclusive breast-feeding, improving the health of children. Many of the statistics are encouraging. For example:

- More than four times as many children received the recommended two doses of vitamin A in 2005 compared to 1999.
- All countries with trend data in sub-Saharan Africa made progress in expanding coverage of insecticide-treated nets, with 16 of these 20 countries at least tripling coverage since 2000.
- In the 47 countries where 95 per cent of measles deaths occur, measles immunization coverage increased from 57 per cent in 1990 to 68 per cent in 2006.
- Rates of exclusive breastfeeding have significantly improved in 16 countries of sub-Saharan Africa over the past decade, with seven of these countries making gains of 20 percentage points or more.



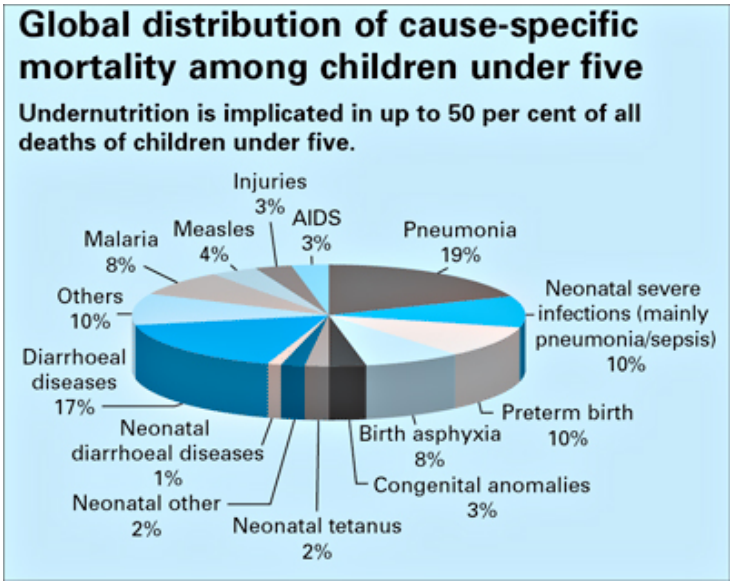
Data reproduced from: United Nations Children's Fund, *The State of the World's Children 2008, Child Survival*, UNICEF, New York, December 2007, pp 6.

- Progress has also been made in expanding coverage of antenatal care and skilled care at delivery – with every region showing improvements during the past decade.
- Between 1990 and 2004, more than 1.2 billion people gained access to improved sources of drinking water, and the world is on track to achieve the UN target for safe water.

These new figures show that progress is possible if we act with renewed urgency to scale up interventions that have proven effective.

2. Increased emphasis on vitamin A supplementation, measles prevention, prevention of mother-to-child AIDS transmission and exclusive breastfeeding are among the several interventions cited as major contributors to reduced child mortality, especially in sub-Saharan Africa. Have any interventions failed to show the anticipated impact, and if so, why?

We know from *The Lancet* series on child survival that all interventions we are scaling up are effective. Whilst we been successful in scaling up the "schedulable" interventions such as antenatal care, vitamin A supplementation, insecticide-treated nets and immunizations, some community-based interventions that rely on social and behaviour change, such as hand-washing, are showing a mixed picture. So, the coverage of some effective interventions is still too low to have the anticipated impact.



Data reproduced from: United Nations Children's Fund, *The State of the World's Children 2008, Child Survival*, UNICEF, New York, December 2007, pp 8.

3. Which countries have benefited the most and which the least from interventions?

Several countries, including Egypt, Eritrea, Bangladesh, Brazil, Indonesia, Iran, Nepal and Vietnam, have reduced their under-five mortality rate by 50 per cent or more since 1990. Another set of countries, including China, Ethiopia, Haiti, Malawi and Mozambique, have decreased their under-five mortality rate by more than 40 per cent since then. Improvements in areas where rapid progress is being made, such as malaria and HIV, are not yet captured by these data, which are based on surveys conducted mostly in 2005; so the real picture is likely to be even more positive. These gains suggest that remarkable progress is possible, despite obstacles such as geographic location or socio-economic disadvantage, when evidence-based, sound strategies, sufficient resources, political will and an orientation towards results are consciously harnessed to improve children's lives.

Of the 11 countries where 20 per cent or more of children die before age five – Afghanistan, Angola, Burkina Faso, Chad, the Democratic Republic of the Congo, Equatorial Guinea, Guinea-Bissau, Liberia, Mali, Niger and Sierra Leone – more than half have suffered a major armed conflict since 1989. Similarly, fragile states, characterized by weak institutions with high levels of corruption, political instability and a shaky rule of law, are often incapable of providing basic services to their citizens. Countries that suffer from food insecurity or are prone to droughts are also at risk of having poorer child survival outcomes. The inability to diversify diets leads to chronic malnutrition for children, increasing their vulnerability to ill health and, ultimately, death.

4. Why has progress in treating childhood illnesses such as pneumonia, diarrhoea and under-nutrition lagged behind reducing under-five mortality?

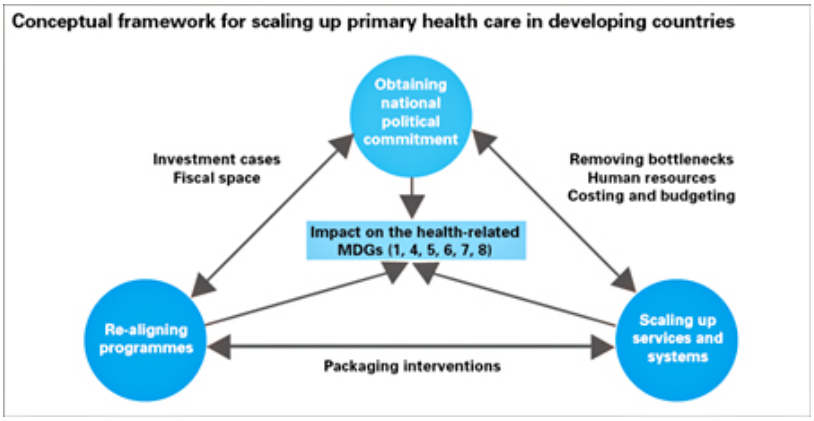
Pneumonia remains the most common cause of death in children under 5 years, taking the lives of more children than AIDS, malaria and measles combined. Yet, the percentage of children under 5 years with suspected pneumonia who receive antibiotics is dismally low – in Haiti for example, this proportion is only 3 per cent. And in sub-Saharan Africa, only 40 per cent of children with suspected pneumonia are taken to an appropriate health provider.

Under-nutrition results from an array of interrelated factors, including inappropriate feeding and care practices, inadequate sanitation, disease, poor access to health services, and weak knowledge of the benefits of exclusive breastfeeding, complementary feeding practices and the role of micronutrients.

Low demand for quality health services among community members or the limited capacity of health facilities and extension workers to deliver essential services may restrict the coverage of intervention packages, as may financial, social and physical barriers to access. Meanwhile, weak health systems, the lack of adequate human resources and health facilities represent major barriers to scaling up integrated approaches to maternal, newborn and child survival, health and nutrition at the community level. In addition, families in the poorest countries, where the majority of children are affected, may not have easy access to health facilities. In-patient treatment may not be an option for parents who cannot leave their homes to

accompany a sick child, and this is where well-supported community-based approaches can pay off, bringing treatment to people's homes, so that sick children can be identified and treated in a timely manner.

5. What lessons have been learned from evolving health-care systems and practices for providing primary health care to mothers, newborns and children?



Data reproduced from: United Nations Children's Fund, *The State of the World's Children 2008, Child Survival*, UNICEF, New York, December 2007, pp 64.

An examination of different approaches to the delivery of essential services from the beginning of the 20th century to the present demonstrates:

- Scaling-up will not be achieved through facility-based services alone. Community partnerships are central to achieving coverage, creating demand and achieving sustainability.

- Vertical programmes have achieved impressive results by focusing on a narrow set of interventions and by monitoring results closely. However, unless systems are supported, those results will be circumscribed and may not be sustained. Ensuring a continuum of care by delivering integrated packages of health, nutrition, HIV, water and sanitation interventions will also be critical to achieving maximal impact on maternal, newborn and child survival.

- The strengthening of 'health-systems for outcomes' has gained prominence in recent years as an effective and sustainable strategy for service delivery. This new approach combines the strength of selective/vertical approaches and comprehensive/horizontal approaches to health-care provision. It emphasizes the scaling-up of evidence-based, high-impact health, nutrition, HIV and AIDS, and water and sanitation intervention packages and practices, and underlines the importance of removing system-wide bottlenecks to health care provision and usage.

- No single approach to child survival and health is applicable in all circumstances. The organization, delivery and intervention orientation of health-care services must be tailored to meet the constraints of human and financial resources, the socioeconomic context, the existing capacity of the health system and, finally, the urgency of achieving results.

6. What do you see as the role of community partnerships in the continuum of care and health systems?

Empowering communities and households to participate in the health care and nutrition of mothers, newborns and children is a logical way of enhancing the provision of care, especially in countries and communities where basic primary health care and environmental services are lacking. As an integral part of the larger health system, community partnerships in primary health care can serve a dual function: actively engaging community members as health workers and mobilizing the community in support of improved health practices. They can also stimulate demand for quality health services from governments.

Community involvement fosters community ownership. It can also add vitality to a bureaucracy-laden health system and is essential in reaching those who are the most isolated or excluded. Community participation is viewed as a mechanism to reduce and eventually eliminate profound disconnections between knowledge, policy and action that impede efforts to address both the supply and demand sides of care. The importance of participation in health care, hygiene practices, nutrition, and water and sanitation services goes beyond the direct benefits to community members as they engage in activities that can impact positively on their health. It forms the heart of a rights-based approach to human progress.

7. How important are national and international partnerships, and partnerships between the private and public sectors in ensuring continuum of health care?

Partnerships at all levels and with all stakeholders are key for accelerating progress towards the achievement of the Millennium Development Goals (MDGs). UNICEF is working closely with United Nations system partners and

with governments, regional and non-governmental organisations, foundations, civil society and the private sector to coordinate activities and to pool expertise and knowledge.

Initiatives and partnerships directed towards improving aspects of maternal, newborn and child health abound and continue to proliferate, with initiatives such as the H8, "International Health Partnerships" and "Harmonization for Health in Africa" starting to address coordination, coherence and harmonization among these partnerships and initiatives.

The basis for action – data, research, evaluation, frameworks, programmes and partnerships – is already well established. It is time to rally behind the goals of maternal, newborn and child survival and health with renewed vigor and sharper vision, and to position these goals at the health of the international agenda. Our challenge now is to act with a collective sense of urgency to scale up that which has proven successful.

8. Can you give some examples of organizations that are doing notable work to improve the state of the world's children, and what are they doing that is making such a difference?

A baby is immunized by health workers in a clinic at a refugee camp in the former Yugoslav Republic of Macedonia.

Many organisations are doing notable work. Some are governments, some are donor organisations, others are non-governmental organisations or sister UN agencies, and all contribute to the achievement of the MDGs in their own ways. For example, the Global Alliance on Vaccines and Immunization (GAVI), the Global Fund to Fight Aids, Tuberculosis and Malaria, and the Bill and Melinda Gates Foundation have mobilized important new resources for major health threats, and have brought much needed political and technical focus to priority diseases or interventions. They have injected new energy into development assistance by supporting the private sector.

Another example is the Measles Initiative, a partnership launched in 2001 that groups UNICEF and WHO with other leading international agencies and prominent private organisations. The main sponsor of the mass campaign to boost measles vaccination, the Measles Initiative shows how a well resourced, targeted and managed global vertical programme can reach scale rapidly and produce dramatic results: More than 217 million children were vaccinated between 2001 and 2005 – mostly in Africa, and the results exceeded the UN target as measles deaths fell by 60 per cent between 1999–2005, with Africa contributing 72 per cent of the absolute reduction in deaths. Estimates concluded that immunization helped avert almost 7.5 million deaths from the disease.

9. How relevant are the findings of the UNICEF report to industrialized nations such as the United States?

We believe the findings of *The State of the World's Children 2008* are relevant to all countries in the world. Global and national numbers are important, but they do not always tell the entire story. Many countries have inequity issues when it comes to health, and the document highlights some of those inequalities that need to be corrected, including adequate nutrition and hygiene; sufficient, skilled delivery and newborn care; and access to basic immunizations, micronutrient supplements and other therapies to combat disease and boost immune systems. The report is also an important tool to inform people all over the world about the status of all children and their needs.

In addition to *The SOWC 2008*, publications from the UNICEF Innocenti Research Centre in Florence discuss the status of industrialized nations in great depth. *Innocenti Report Card 7*, "An Overview of Child Well-Being in Rich Countries," released last year, for example, provides a comprehensive picture of child well-being in economically advanced nations through the consideration of six dimensions: material well-being; health and safety; education; peer and family relationships; behaviours and risks; and young people's own subjective sense of well-being. The report card shows that among all of the 21 OECD countries assessed, from the overall top-ranking Netherlands to the bottom-ranking United States and United Kingdom, there are improvements to be made and that no single OECD country leads in all six areas. (To access *Report Card 7*, go to http://www.unicef-irc.org/publications/article.php?type=3&id_article=49 and click on the link.)

10. Can you shed some light on special approaches that might be needed to improve child survival and maternal well-being in industrialized nations?

The problems in industrialized countries might be different, but there always will be behaviours that can be improved, as

outlined in *Innocenti Report Card 7*. We have learned from many countries, for example, that the community component to health is extremely important, especially when it comes to communication for social and behaviour change. It therefore behooves all nations to support current as well as burgeoning community partnerships, and to pursue the development of new such initiatives. Perhaps we also need to learn more about social networks and their role in industrialized countries and see how we can build on these to provide to mothers and children in need.

While there's no definitive approach or solution, the answer to improving child survival and maternal well-being, especially in industrialized countries, may lie in the maxim, "To improve something, first measure it." The decision to measure helps set directions and priorities by demanding a degree of consensus on what is to be measured – and what constitutes progress. Over the long-term, measurement serves as the handrail of policy, keeping efforts on track towards goals, encouraging sustained attention, giving early warning of failure or success, fuelling advocacy, sharpening accountability, and helping to allocate resources more effectively. In short, a multi-dimensional approach to well-being is necessary in industrialized and developing countries alike – one that encourages monitoring and measurement, permits comparison, and stimulates the discussion and development of policies to improve the lives of mothers and children.

11. What do you see as the biggest challenges over the next decade to achieving the United Nations Millennium Development Goals (MDGs), the majority of which pertain to children?

It's a formidable list: poverty; inequalities in child survival; conflict; and the scaling-up of community-based interventions that rely on social and behaviour change.

Poverty excludes millions of women and children from progress. The inequalities in child survival between poor and better-off children are stark. For countries with available data, children in the poorest 20 per cent of households are far more likely to die before their fifth birthday than children living in the richest quintile. Meanwhile, access to basic interventions remains spotty; all children, their mothers and communities deserve access to effective interventions, including new technologies such as new vaccines, artemisinin-based combination therapy, zinc and antibiotics, and their provision will be crucial going forward if the MDGs are to be achieved. Wars and internecine conflicts cripple a nation's ability to focus on issues of public health and provide basic services; and they impede, if not destroy, progress on every level.

Scaling-up existing interventions is also critical to accelerating progress on the health-related MDGs for children and women – particularly in sub-Saharan Africa and South Asia, which together accounted for more than 80 per cent of all child deaths in 2006. Scaling-up involves a complex range of actions, many of which are interrelated, to both achieve breadth and ensure the long–term sustainability of the expansion. At the programmatic and policy levels, it is not enough simply to expand the delivery of packages of low-cost, proven interventions: behavioural, institutional and environmental impediments that can impede access must also be addressed as part of the scaling-up process. Success requires an in-depth understanding of these obstacles, as well as of the strategies for circumventing them.

12. What, in your opinion, are the biggest takeaways from this UNICEF report? The biggest disappointments?

While recent data show a fall in the rate of under-five mortality, there are still too many children dying every year. *The SOWC 2008* goes beyond the numbers to suggest actions and initiatives that should lead to further progress. It looks at several of the most promising approaches – community partnerships; the continuum of care framework; and health-system strengthening for outcomes – all aiming at reaching those mothers, newborns and children who are currently excluded from essential interventions.

The SOWC 2008 examines these lessons and highlights the most important emerging precepts, including:

- The need to focus on the countries and communities where child mortality rates and levels are highest, and on those that are most at risk of missing out on essential primary health care.
- The merits of packaging essential services together to improve the coverage and efficacy of interventions.
- The vital importance of community partnerships in actively engaging community members as health workers and mobilizing the community in support of improved health practices.
- The imperative of providing a continuum of care across the life cycle, linking households and communities with outreach and extension services and facility-based care.
- The benefits of a strategic, results-oriented approach to health-system development with maternal, newborn and child care as a central part.
- The crucial role of political commitment, national and international leadership and sustained financing in strengthening health systems.
- The necessity for greater harmonization of global health programmes and partnerships.

Global Dump Soft Drinks Campaign

CECHE Collaborates to Dump Soda

Once a distinctly American problem, the prevalence of overweight and obesity is increasingly becoming a global worry, with an upswing in obesity and overweight leading to increases in diet-related diseases and mortality in less developed countries.

Surges in soft drink consumption contribute to this problem. In fact, less developed countries now represent the largest growth markets for soft drink producers, as consumption has leveled off, or slightly declined, in the United States and parts of Europe. Consumers in countries such as Mexico, Egypt and China are currently being targeted by the soft drink industry with aggressive marketing campaigns, sometimes aimed at children and youth.

To raise awareness of the growing problem and foster improvement, CECHE is collaborating with Center for Science in the Public Interest (CSPI) on its Global Dump Soft Drinks Campaign. The initiative, which launched in October 2007 at the Consumers International Conference in Sydney, aims to reduce consumption of high-calorie carbonated beverages worldwide to improve diet and health. It seeks to establish working relationships with industry leaders in areas where progress can be made and to provide communications points for advocates, including a detailed Web site, www.dumpsoftdrinks.org, which spotlights the program's mission, features a full description of the health repercussions of soft drink consumption and showcases prominent international media coverage surrounding the initiative.

CECHE has specifically provided support for CSPI's collaboration with VOICE, a consumer-advocacy coalition in India that is among more than a dozen non-governmental organizations partnering with CSPI to "dump soda." Citing rapidly rising rates of overweight and obesity and the connection to increased risk of heart disease, diabetes and other diet-related illnesses, VOICE has urged India's Prime Minister Manmohan Singh and the country's ministers for Health & Family Welfare and Consumer Affairs to safeguard the health of the food supply and Indian youth by curbing soft drinks marketing, particularly to children. VOICE has also demanded the promotion of lower-sugar products; a reduction in portion sizes; a limit on sponsorships; a value-added tax on soft drinks to fund physical activity and nutrition education programs; and mandatory calorie labeling and serving sizes. In addition, VOICE is working with CECHE and CSPI on a nationwide push to remove soft drinks from Indian schools.

VOICE is bolstering its efforts by mounting local media campaigns and putting pressure on industry; and leading beverage makers PepsiCo and Coca-Cola are reaching out to discuss demands.

On the international front, in January 2008, CSPI reported the launch of a number of "dump soft drinks" movements, including one in New Delhi supported by the Indian Federation of Consumer Organizations; one in Malaysia organized by the Consumers Association of Penang; and another in Stockholm under the auspices of the Swedish Consumers Coalition. National campaigns have also kicked off in Mexico, Australia, Uganda and Canada.

As part of these initiatives, the consumer organizations wrote letters calling on Coca-Cola and PepsiCo to:

- Cease all marketing of sugar-laden or caffeinated beverages to children under 16
- Stop selling sweetened beverages, including sports drinks and non-carbonated fruit-flavored beverages and teas, in all public and private elementary, middle and high schools

N2O NATION THE STAR, SATURDAY 15 DECEMBER 2007

'Soft drinks can damage cells'

CAP cites recent study in urging Govt to phase out common preservative

»Once the cell is damaged, it might eventually lead to degenerative diseases«

S.M. MOHD IDRIS

Police defend right to reveal probe info to the media

- Display prominently the calorie content per serving on the front labels of drink containers
- Include rotating consumer alert messages on the labels of sugary beverages
- Limit sponsorships promoting physical activity and health to blind trusts overseen by government agencies.

The letters also called on the companies not to oppose small taxes on soft drinks, the revenues from which could be used for health-related programs. Soft drinks are already taxed in some jurisdictions in the United States and Canada, and last year in America, Coke and Pepsi actually supported legislation that would have removed non-diet soft drinks from schools. Coca-Cola has also agreed to front-label disclosure of calorie content in Australia.

Advances like these are a step in the right direction, but they are often confined to one country, in response to national political pressures. Going forward, CSPI, CECHE and the campaign's partners will continue their international push to limit the marketing and sale of soft drinks worldwide in an effort to reduce exposure and consumption, and improve global health.

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