

PROGRESS IN IMPLEMENTING THE CHILD SURVIVAL STRATEGY IN THE AFRICAN REGION

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Under-five mortality rate in the African Region was estimated at 145/1,000 live births in 2007. These deaths were the result mainly of preventable or treatable conditions. A child survival strategy for the African Region was developed by WHO, UNICEF and World Bank and adopted by the fifty-sixth WHO Regional Committee in 2006 to address this high mortality rate.¹ This report, which is a review made using reports and the results of a questionnaire sent to countries, summarizes progress in implementing the strategy as at December 2009 and proposes next steps for action.

Significant achievement has been made in the areas of policy, strategy and plan development; capacity building; partnerships and communication strategies; operations research, documentation and monitoring and evaluation. Also in scaling-up of child survival interventions such as measles vaccination coverage, insecticide-treated nets use in children and provision of antiretroviral drugs to prevent mother-to-child transmission of HIV. Currently, 21 countries are implementing the Integrated Management of Childhood Illness strategy in more than 75% of the districts.

Despite the achievements in some areas, coverage of some effective interventions remains low. Various health system challenges hamper the progress of child survival. These include inadequate country-level funding for scaling-up effective interventions, inadequate monitoring of coverage of interventions and human resource limitations.

In order to increase coverage of effective child survival interventions and accelerate progress in implementation of the regional child survival strategy, the paper recommends several actions including the improvement of coverage of key child survival interventions and mobilization and allocation of resources to implement national child survival scale-up strategies and plans.

RÉSUMÉ

En 2007, dans la région africaine, le taux de mortalité des enfants de moins de cinq ans a été estimé à 145 pour 1'000 naissances vivantes. Ces décès étaient principalement la conséquence de conditions prévisibles ou traitables. Pour s'attaquer à ce taux de mortalité élevé¹, l'OMS, l'UNICEF et la Banque Mondiale ont élaboré une stratégie de survie de l'enfant qui a été adoptée en 2006 par le cinquante-sixième Comité régional de l'OMS. Ce rapport, qui consiste en une révision faite en utilisant les rapports et les résultats d'un questionnaire envoyé aux pays, résume les progrès accomplis en mettant en œuvre la stratégie à la date de décembre 2009 et propose les prochaines étapes d'action.

Des réalisations significatives ont été accomplies dans les domaines de la politique, de la stratégie et du plan

de développement; du renforcement des capacités, des partenariats et des stratégies de communication, des recherches d'opérations, de documentation et de suivi et d'évaluation ainsi que d'augmentation des interventions de survie de l'enfant telles que la couverture de la vaccination contre la rougeole, l'utilisation de moustiquaires imprégnées d'insecticide chez l'enfant et la fourniture de médicaments antirétroviraux pour prévenir la transmission mère-enfant du VIH. Actuellement, 21 pays mettent en œuvre la stratégie de gestion intégrée des maladies de l'enfance dans plus de 75% des districts.

Malgré les progrès accomplis dans certains domaines, la couverture de certaines interventions efficaces reste faible. Plusieurs défis relevés par des systèmes de santé entravent

le progrès de la survie des enfants. Ceux-ci comprennent le financement insuffisant au niveau des pays pour augmenter les interventions efficaces, l'insuffisance de suivi de la couverture des interventions et la restriction des ressources humaines.

Afin d'augmenter la couverture des interventions efficaces de survie des enfants et accélérer les progrès dans la mise en œuvre de la stratégie régionale de survie de l'enfant, le document recommande plusieurs actions, notamment l'amélioration de la couverture des interventions clés pour la survie des enfants ainsi que la mobilisation et l'allocation de ressources nécessaires pour mettre en œuvre, à l'échelle nationale, des stratégies et des plans pour la survie des enfants.

SUMÁRIO

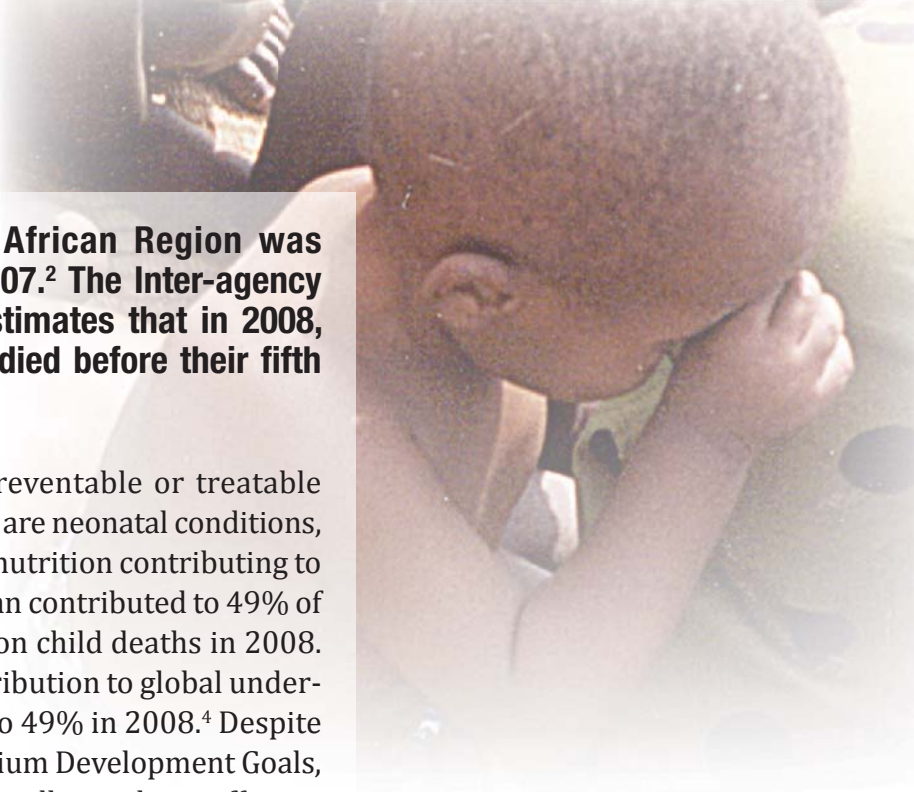
Em 2007, na Região Africana a taxa de mortalidade dos menores com menos de cinco anos estimava-se em 145/1.000 nos partos de nados-vivos. Estas mortes foram, na sua maioria, consequências de condições susceptíveis de serem prevenidas ou tratadas. Uma estratégia para a sobrevivência infantil na Região Africana foi desenvolvida pela OMS, pela UNICEF e pelo Banco Mundial e adoptada na quinquagésima sexta sessão do Comité Regional da OMS em 2006 para combater a elevada taxa de mortalidade. Este relatório, que representa uma revisão feita com base na análise de relatórios e dos resultados dos questionários enviados aos países, resume o progresso na implementação da estratégia relativamente à situação em Dezembro de 2009 e apresenta propostas para os próximos passos a dar.

Avanços significativos foram dados na área de desenvolvimento de políticas, estratégias e de planos; capacitação; parcerias e estratégias de comunicação; investigação, documentação e monitorização e na avaliação e no aumento das intervenções com vista a aumentar a sobrevivência das crianças como a cobertura da vacinação contra sarampo, utilização de redes tratadas com insecticidas para crianças e o fornecimento de medicamentos antiretrovirais para prevenir a transmissão do HIV de mães para filhos. Actualmente 21 países estão a implementar a estratégia da Gestão Integrada de Doenças Infantis em mais de 75% dos distritos.

Apesar dos avanços em algumas áreas, a cobertura de algumas intervenções eficazes permanece baixa. Diversos

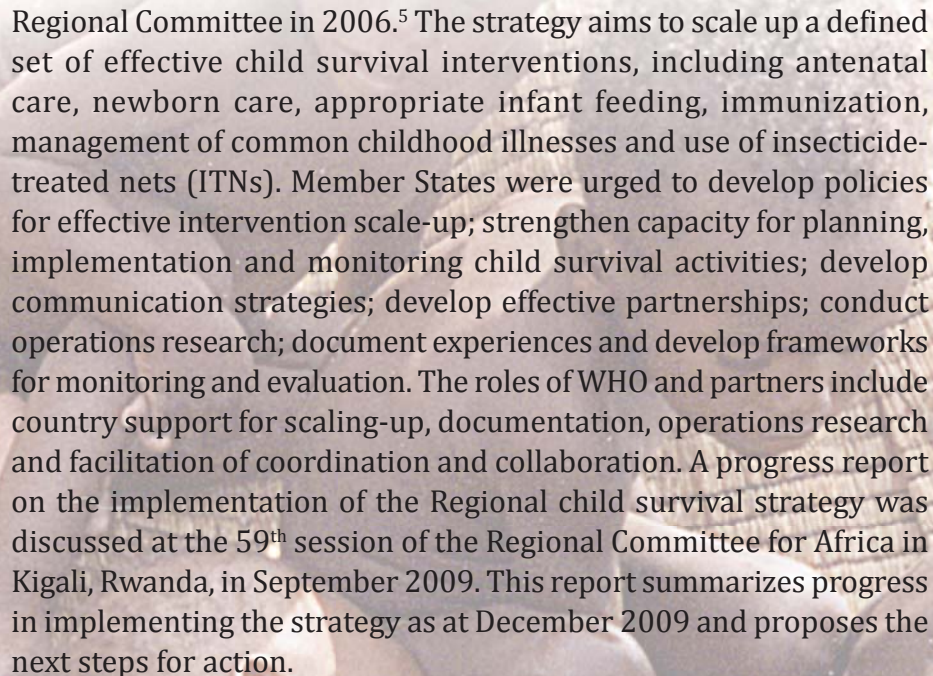
desafios a nível do sistema de saúde dificultam o progresso relativo à sobrevivência das crianças. Entre outros um financiamento inadequado a nível nacional para o aumento de intervenções eficazes, uma monitorização inadequada da cobertura das intervenções e limitações ao nível dos recursos humanos.

Para aumentar a cobertura de intervenções eficazes relativas à sobrevivência das crianças e para acelerar o progresso na implementação da estratégia regional, o relatório propõe diversas medidas, incluindo a melhoria da cobertura das intervenções chave e a mobilização e atribuição de recursos para a implementação nacional de estratégias e planos para um aumento da sobrevivência das crianças.



The under-five mortality rate in the African Region was estimated at 145/1,000 live births in 2007.² The Inter-agency Group for Child Mortality Estimation estimates that in 2008, 8.8 million children born alive globally died before their fifth birthday.³

These deaths were mainly the result of preventable or treatable conditions. Major causes of childhood deaths are neonatal conditions, malaria, pneumonia, diarrhoea, with under-nutrition contributing to over a third of the deaths. Sub-Saharan African contributed to 49% of the global child mortality, totalling 4.4 million child deaths in 2008. It is worth noting that the sub-Saharan contribution to global under-five mortality increased from 19% in 1970 to 49% in 2008.⁴ Despite Member States' commitments to the Millennium Development Goals, the rate of decline in under-five mortality is still grossly insufficient to reach MDG goal 4 by 2015. The World Health Organization (WHO) African Region has made the least progress in improving child survival. Only five countries (Algeria, Cape Verde, Eritrea, Mauritius and Seychelles) in the Region are on track to the MDG 4 targets on child mortality reduction.



A child survival strategy for the African Region was developed by WHO, UNICEF and the World Bank and adopted by the fifty-sixth WHO Regional Committee in 2006.⁵ The strategy aims to scale up a defined set of effective child survival interventions, including antenatal care, newborn care, appropriate infant feeding, immunization, management of common childhood illnesses and use of insecticide-treated nets (ITNs). Member States were urged to develop policies for effective intervention scale-up; strengthen capacity for planning, implementation and monitoring child survival activities; develop communication strategies; develop effective partnerships; conduct operations research; document experiences and develop frameworks for monitoring and evaluation. The roles of WHO and partners include country support for scaling-up, documentation, operations research and facilitation of coordination and collaboration. A progress report on the implementation of the Regional child survival strategy was discussed at the 59th session of the Regional Committee for Africa in Kigali, Rwanda, in September 2009. This report summarizes progress in implementing the strategy as at December 2009 and proposes the next steps for action.

THIS PAPER RECOMMENDS SEVERAL ACTIONS INCLUDING THE IMPROVEMENT OF COVERAGE OF KEY CHILD SURVIVAL INTERVENTIONS AND MOBILIZATION AND ALLOCATION OF RESOURCES TO IMPLEMENT NATIONAL CHILD SURVIVAL SCALE-UP STRATEGIES AND PLANS.

METHODS

This review was carried out using reports and the results of a questionnaire sent to countries. The indicators tracked for progress made were selected based on formerly agreed upon child health programme indicators as well as those that reflect coverage of the interventions proposed in the Regional child survival strategy.

Information on progress made in selected child survival indicators was obtained from World Health Organization reports from Regional, intercountry and country levels. These included annual, semi-annual and quarterly reports. Baseline information was obtained from reports where available.

In addition, a self-administered quantitative questionnaire was sent to WHO child health focal points to obtain additional information on some indicators. The questionnaire was developed by the WHO Division of Family and Reproductive Health. It was made up of 21 questions divided into various sections which included policies, strategies and plans, operations research, newborn and child health. Questions included availability of national child health policies, strategies and plans, geographic coverage of Integrated Management of Childhood Illness (IMCI), expansion of components of IMCI to include HIV, Newborn (0-7days) and Low Osmolarity Oral Rehydration Salts/Zinc. It also included questions on community case management of malaria and pneumonia. The questionnaire was sent to WHO country child health focal points of the 46 countries in the WHO African Region. Of these, 43 countries responded. All responses were included in the analysis.

Selected information from various reports on progress in child survival was summarized. Data from the questionnaire were entered into a spreadsheet. This was also summarized and analyzed.

PROGRESS MADE

POLICY, STRATEGY AND PLAN DEVELOPMENT

As of December 2009, 27 countries in the WHO African Region had developed comprehensive national child survival policies, strategies and plans;⁶ 24 countries adopted low osmolarity oral rehydration salts and zinc in management of childhood diarrhoea; in addition, 18 countries adopted policies of community case management for pneumonia and other childhood illnesses.

CAPACITY BUILDING

Since 2006, the capacity of 185 child health managers from 19 countries⁷ was developed to improve their skills in the management of child health programmes. Thirty-one countries built capacity for neonatal survival activities since adoption of the Child Survival Strategy during the same period. Capacity building in case management of childhood illness has continued in countries, both at health facility level as well as at community level.

PARTNERSHIPS AND COMMUNICATION STRATEGIES

From 2006 to date, national partnerships for maternal, newborn and child health were formed in seven countries.⁸ Maternal and child survival country profiles were developed through joint global tracking of progress towards MDGs 4 and 5. In addition, 11 countries⁹ promoted key family and community practices through communication and social mobilization.

OPERATIONS RESEARCH, DOCUMENTATION AND MONITORING AND EVALUATION

Since adoption of the child survival strategy, seven countries¹⁰ have conducted Child Health Facility Surveys to assess the quality of care provided to sick children at first level health facilities. Child health research has also been conducted in countries, including Ghana, Kenya and Uganda.

Results from these surveys suggest that IMCI in the presence of some practical and affordable health system tools (training, drugs, referral and supervision) is feasible for implementation in most of the African countries and is likely to lead to improved quality of care in the health facilities. Results show that IMCI case management training

leads to correct assessment and classification of illnesses of children presenting to health facilities.

In Tanzania where the analysis was stratified by status of training of health workers, the survey showed a statistically significant difference in the proportion of children correctly managed when health workers trained in IMCI case management examined the children. The same study in Tanzania showed that IMCI had contributed to 13% mortality reduction in children U5 years over a two years period.¹¹

WHO, UNICEF, USAID/AED/Africa 2010 and Regional Centre for Quality Health Care, Uganda, supported an assessment of utilization of oral rehydration therapy in Benin, Ethiopia, Mali, Senegal and Zambia. These assessments have been

completed and data analysis/report writing is in progress. The results of these assessments will inform childhood diarrhoea case management strategies in the Region.

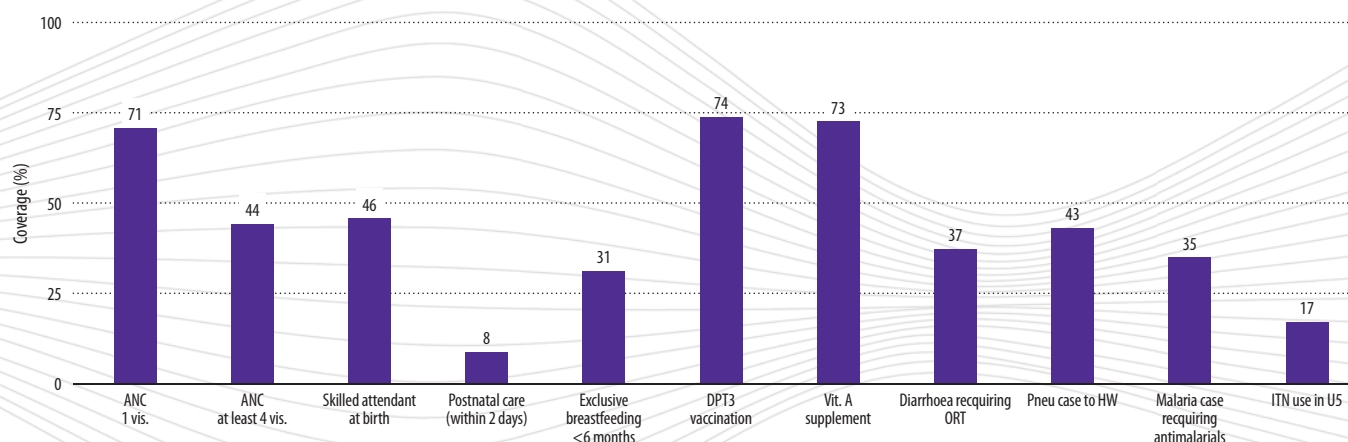
SCALE-UP OF CHILD SURVIVAL INTERVENTIONS

Since adoption of the strategy, Integrated Child Health Weeks have been conducted in 13 countries.¹² During these Weeks, essential interventions such as vaccinations, vitamin A supplementation, de-worming medicines and ITNs were provided to augment routine services. Increased measles vaccination coverage has contributed to an 89% decrease in measles deaths in the Region between 2000 and 2007.¹³ Recent data from 18 countries, estimates that ITN use in children at 23% in 2007.¹⁴ Provision of

antiretroviral drugs to prevent mother-to-child transmission of HIV (PMTCT) improved from 31% in 2006 to 43% in 2007 for Eastern and Southern Africa and from 7 to 11% for West and Central Africa.¹⁵ Children under 15 years on antiretroviral therapy increased from 5,000 in 2005 to 158,000 in 2008.¹⁵ Figure 1 below summarises the current coverage of key child survival interventions.

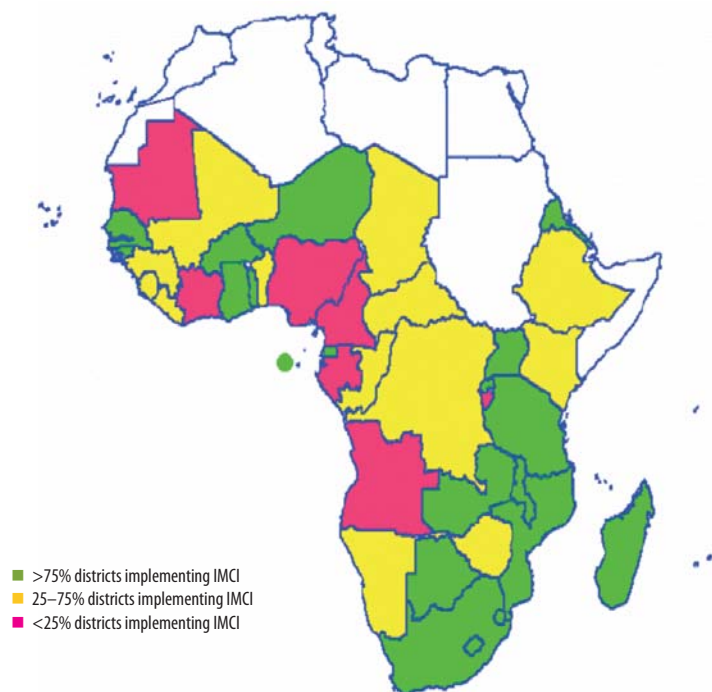
As shown in Figure 2, 21 countries are implementing the Integrated Management of Childhood Illness (IMCI) in more than 75% of the districts.³ Thirty-two countries¹⁶ have adapted their IMCI guidelines to include HIV and 36 countries¹⁷ have included the first week of life (0–7 days). The expansion of IMCI contributes to improved capacity for child health care in countries.

Figure 1: Coverage of child survival interventions along the continuum of care, WHO African Region, 2008



Source: WHO, World Health Statistics, 2009, UNICEF, SOWC, 2010.

Figure 2: Proportions of districts implementing the Integrated Management of Childhood Illness Strategy in countries of the Region, June 2009



Source: World Health Organization/Regional Office for Africa, Division of Family and Reproductive Health, June 2009.

Malawi, Uganda, Zambia and Zimbabwe built capacity of 15 resource persons on home-based newborn care. Botswana, Lesotho and Namibia built the capacity of 21 programme managers and pre-service teachers on Essential Newborn Care at health facility level.

Ethiopia, Gabon, Kenya, Malawi, Nigeria and Zambia built the capacity of over 150 tutors of training institutions in infant and young child feeding (IYCF) counseling. Five countries¹⁸ reviewed their IYCF policies and strategies. Kenya, Nigeria and Zambia documented their best practices and experiences in scaling up infant feeding

activities. Fourteen countries¹⁹ adapted the new WHO child growth standards bringing the total number of adapting countries to 20.

Discussion

As a result of implementation of various child survival programmes such as immunization campaigns, vitamin A supplementation and use of insecticide-treated nets, some countries have recorded increased coverage in key interventions.


Despite the achievements in some areas, coverage of some effective interventions remains

low. Exclusive breastfeeding in the first six months of life and appropriate care seeking for acute respiratory infections have remained static between 2005 and 2007. The rates for appropriate treatment for diarrhoea and fever declined over the same period. The results reported in 2009 on coverage of exclusive breastfeeding in the first six months of life, utilization of oral rehydration therapy and continued feeding during childhood diarrhoea remain low. The percentage of children under five years of age with suspected pneumonia who are taken to an appropriate health care provider is reported to be 46% while the percentage of those with fever receiving antimalarial drugs is 35% in sub-Saharan Africa. A high coverage of all key effective child survival interventions is vital for reduction of child deaths.

Disaggregation of the Regional averages of coverage of some child survival interventions shows that some countries have made significant progress in areas like exclusive breast feeding in the first six months of age and vitamin A supplementation. However, the overall situation remains severe at the Regional level.

Various health system challenges hamper child survival progress. These include inadequate

country-level funding for scaling up effective interventions, inadequate monitoring of coverage of interventions and human resource limitations. HIV infection and conflict are key underlying factors in countries making the least progress in child mortality reduction. Accelerated efforts are required to achieve set targets.

The review of the progress in implementation of the Regional child survival strategy shows modest improvement in coverage of some child survival indicators. However, there is an urgent need to accelerate efforts to ensure high coverage, particularly in areas of greatest need. 

In order to increase coverage of effective child survival interventions and accelerate progress in implementation of the Regional child survival strategy, countries, with support from partners, should:

- 1 Use available opportunities to improve coverage of key child survival interventions e.g. Child Health Weeks/Days, vaccination campaigns and introduction of new vaccines.
- 2 Mobilize and allocate appropriate resources to implement national child survival scale-up strategies and plans, using domestic resources as well as external funding opportunities like The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and The Global Alliance for Vaccines and Immunization (GAVI).
- 3 Develop and/or implement monitoring frameworks to regularly monitor progress in coverage of child survival interventions to facilitate remedial actions at district levels.
- 4 Consider allowing, facilitating, and providing training for management of common childhood illnesses and conditions like malaria, diarrhoea and pneumonia, to Community Health Workers, particularly in places where access to health facilities and/or human resources are limited.

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