WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTE

REGIONAL OFFICE FOR THE WESTERN PACIFIC
BUREAU REGIONAL DU PACIFIQUE OCCIDENTAL

REGIONAL COMMITTEE

WPR/RC56/8

Fifty-sixth session
Noumea. New Caledonia
19–23 September 2005

28 July 2005

ORIGINAL: ENGLISH

Provisional agenda item 12

CHILD HEALTH

Some 3000 children under five years of age die every day in the Western Pacific Region from common neonatal conditions, pneumonia and diarrhoea. Undernutrition also is common and increases the risk of death. Most child deaths occur where basic health care is in short supply or barriers prevent access to families seeking care. The majority of these child deaths could be avoided with readily available, cost-effective interventions.

The Regional Committee at its fifty-fourth session urged Member States, particularly those with high child mortality, to place child health higher on their political, economic and health agendas.[1] This prompted a new drive to reduce child mortality in Member States, particularly in areas of greatest need in line with Millennium Development Goal4: reduction of the under-five mortality rate by two thirds between 1990 and 2015.

As a response, WHO and the United Nations Children's Fund (UNICEF) have collaborated in developing a joint Regional Child Survival Strategy that aims to reduce inequities in child survival and to achieve national targets for MDG 4 by accelerating and sustaining actions to reduce childhood mortality. The strategy advocates universal access to an essential package of key child survival interventions delivered through integrated approaches. Core child survival indicators have been identified to regularly monitor progress and to generate benchmarks for stepped-up advocacy and resource mobilization. Collaboration of all stakeholders under strong national leadership is necessary to ensure a continuum of care and synergistic, measurable implementation of the essential package.

The Regional Committee is requested to discuss and endorse the draft WHO/UNICEF Regional Child Survival Strategy.

[1] Resolution WPR/RC54.R9.

1. CURRENT SITUATION

Some 3000 children under five years of age continue to die every day in the Region. Among those, more than 40% are babies that die within the first month due to infections and complications related to pregnancy and childbirth. Most post-neonatal deaths are due to just a few common preventable and treatable communicable diseases and undernutrition.

Most childhood deaths occur in less developed countries and areas in poor communities in more developed countries, reflecting enormous disparities among different geographical areas and population groups between and within countries of the Region. Thirty-fold differentials in the reported under-five mortality rates persist in the Region in 2005.

Concerned about the situation and committed to a promise contained in the Development Goals of the United Nations Millennium Declaration to reduce the under-five mortality rate by two thirds between 1990 and 2015 (Millennium Development Goal 4), the WHO Regional Committee at its fifty-fourth session urged Member States, in particular those with high child mortality, to place child health higher on their political, economic and health agendas, and to ensure the provision of health care and medical assistance to all children in need. This prompted a new drive to reduce child mortality in Member States, particularly in areas of greatest need.[2] This momentum was followed by a worldwide emphasis on the unmet needs of mothers, newborns and children by *The World Health Report 2005 - Making Every Mother and Child Count.* Consequently, the World Health Assembly in May 2005 adopted resolution WHA58.31 highlighting the importance of continuum of care and the need to commit resources to ensure universal coverage of maternal, newborn and child health interventions.

As a regional response to accelerate and sustain actions for achieving MDG 4, the Regional Office for the Western Pacific in collaboration with the UNICEF East Asia and Pacific Regional Office has developed a joint WHO/UNICEF Regional Child Survival Strategy that addresses the recognized gaps in child survival. Signifying strong WHO/UNICEF collaboration and a united approach to achieving MDG 4 in the Region, this strategy is a result of an extensive dialogue and consultation that has involved technical experts from several child health-related programmes at regional and country offices and WHO Headquarters and UNICEF, as well as partner agencies and a number of institutions in Member States. The major thrust of the strategy is belief that all children in the Region should be granted access to an essential package of interventions for child survival, and that it is in fact urgent to take to scale the life-saving measures in the areas of greatest need.

---

[2] *ibid.*

2. ISSUES

2.1 Under-five mortality situation is still a concern

After an impressive decline in the 1980s, the reduction in child mortality has slowed down in the Region. Infant and under-five mortality rates are even increasing in some countries and areas. Stepped-up efforts are needed now to improve child survival if MDG 4 is to be achieved within a decade.

2.2 Preventable and treatable conditions claim children's lives

The majority of childhood deaths are due to common preventable and treatable communicable diseases, undernutrition and neonatal events. Child survival interventions are widely known and their cost-effectiveness proven. While evidence-based strategies to save children's lives have been implemented to a limited degree, they have not received the attention and investment necessary to take them to scale.

2.3 Wide disparities in child health

Thirty-fold differentials in child mortality rates between countries reflect the enormous inequality for child survival in the Region. Huge disparities are recorded also within countries. Financial, geographic and other barriers hamper access to health care, the utilization of which may also be affected due to the poor quality of care. As a result, a vast number of disadvantaged children remain deprived of the most basic, essential health care that is available to their better-off counterparts.

2.4 Investment in child survival is insufficient

In many countries of the Region, the weak status of child survival can be traced to insufficient funding. Dependent on one hand on long-term investment by the government for effective, efficient and equitable health systems, and on strategic aid from partner agencies on the other, child survival has often been at the loosing end. Without significantly increased human and financial resources to match the magnitude of the problem, there is little hope that the needs for improved child survival will be met.

2.5 Child survival has low visibility and lacks focus

A lack of focus on the major causes of mortality, failure to invest sufficiently in the delivery of proven child survival interventions, competing priorities, and inadequate coordination among all stakeholders together contribute to the slow and patchy progress in child health. Compared with high-profile health problems, child health has had low visibility and inadequate support to promote the moral and economic imperative of investing in children as the future of the Region.

3. ACTIONS PROPOSED

The WHO/UNICEF Regional Strategy for Child Survival has been developed to address the above issues. It advocates universal access to an essential package of key child survival interventions delivered through integrated approaches, with an emphasis on intensified action for countries and areas with marginalized and poor populations and high infant and under-five mortality. Specifically, the Strategy calls for the following crucial actions:

3.1 Affirm unified commitment to child survival through one formal coordinating mechanism

Strong leadership and commitment for child survival is the basis for placing child survival firmly on the political, economic and development agenda. A national body, led at the highest possible level, should be established to coordinate child survival actions at the country level, including active participation from all relevant sectors and stakeholders.

3.2 Consolidate partnerships for one national child survival plan

A national strategic plan of action for child survival should be developed and enacted either as part of an existing strategic policy framework or as a special priority policy. National plans, developed with multi-stakeholder participation to ensure their synergistic implementation, should clearly assign the due prominence of child health as part of the overall health agenda. Plans must be linked to credible levels of funding from government and external sources and include aspects of human resources development and health system strengthening needed for child survival at national and subnational levels.

3.3 Ensure universal access to the essential package for child survival with outcome-oriented monitoring and evaluation

Core child survival indicators that have been identified to directly measure the coverage of the key elements of the package and to generate benchmarks for stepped-up advocacy and resource mobilization are at the heart of the Regional Strategy. Their regular monitoring, complemented by impact evaluations every four or five years, through a mechanism to which all stakeholders adhere, is crucial in order to standardize indicators for comparability, avoid duplication of effort, and ensure the government's leading role to oversee child survival activities and progress.

3.4 Raise the profile of child survival through advocacy and communication

Increased awareness of child survival within the community, including village leaders, parents, teachers, the media and the private sector, will help focus attention on solutions. Respected national figures and role models may be engaged as champions for child survival. All available channels for raising the profile of child health should be used through the development and dissemination of advocacy materials. Greater emphasis must be put on community-derived communication strategies that reflect local ideas and beliefs about child survival.

3.5 Enable, accelerate and sustain progress through resource mobilization

To achieve MDG 4 in the Region, human and financial resources should match the need to deliver the essential package. Therefore, substantial additional investment in child health will be required through increased government spending and external assistance. Child survival should remain at the core of the development agenda for a country and its health system, with child survival efforts streamlined within comprehensive health sector investment plans, ensuring sufficient resources to the supply of services and protecting families from exclusion of care due to barriers to access. Adequate and stable financing for child survival is an investment for the future.

The Regional Committee is requested to review and endorse the joint WHO/UNICEF Regional Child Survival Strategy, and adopt a resolution that urges Member States to translate the Regional Strategy into country-specific commitments for accelerated and sustained child survival actions in countries and areas of greatest need.

ANNEX

WHO/UNICEF Regional Child Survival Strategy

Accelerated and Sustained Action
Towards MDG 4

Annex

Contents

List of abbreviations 9

Foreword 10

1. Background 11

2. Rationale for accelerated and sustained action for child survival 12

3. Strategy overview 16

4. Essential package for child survival 16

5. Contributing actions for child survival that strengthen the impact of the essential package 18

6. Strategic approaches for child survival 19

7. Addressing diversity and inequity across and within countries 23

8. Monitoring and evaluation of child survival activities 26

9. The way forward: organize and mobilize 29

References 31

APPENDIX - Resolution WPR/RC54.R9 33

Annex

List of abbreviations

ACT	Artemisinin-based Combination Therapy
AIDS	Acquired Immunodeficiency Syndrome
BCG	Bacille, Calmette - Guerin
BFHI	Baby Friendly Hospital Initiative
DHS	Demographic and Health Survey
EPI	Expanded Programme on Immunization
IECD	Integrated Early Childhood Development
IMCI	Integrated Management of Childhood Illness
IMPAC	Integrated Management of Pregnancy and Childbirth
IYCF	Infant and Young Child Feeding
HIV	Human Immunodeficiency Virus
GDP	Gross Domestic Product
LLIN	Long-lasting Insecticide-treated Nets
OECD	Organization for Economic Cooperation and Development
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PMTCT	Prevention of Mother-to-Child Transmission of HIV
MDG	Millennium Development Goals
MICS	Multi-indicator Cluster Survey
MPS	Making Pregnancy Safer
NGO	Nongovernmental organization
UNICEF	United Nations Children's Fund
U5MR	Under-5 Mortality Rate
WHO	World Health Organization

Annex

Foreword

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

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

We, therefore, need to transform our policy parameters. It is our moral imperative to change the course of action in the Region and translate the promises that have been made at numerous international conferences into action. Children represent the Region's future. Improving child health will benefit the economic and social development of the Member States, provide a major contribution to sustainable poverty reduction, and guarantee that the rights of children are fulfilled. But improved child survival will not be possible without the determination to give children a voice and a commitment to place child health high on the political, economic and development agendas. Increased financial commitments by both national governments and donors also are needed.

The purpose of this joint WHO/UNICEF Regional Strategy for Child Survival is to mobilize the resources of the two organizations most involved in child health to stimulate an accelerated drive to save children's lives, making concrete the commitment of all Member States to the development goals of the United Nations Millennium Declaration, most specifically Millennium Development Goal4: reduce child mortality. The Strategy offers a unified direction and a description of the actions necessary to successfully implement life-saving interventions. As such, it can be used to guide countries in the Region in their efforts to improve child survival. It can also serve as an advocacy document for focused and convergent programmes and donor coordination. Progress in child health can only be realized if inequities in the health and well being of children in the Region are addressed. This strategy focuses on children from birth to 5 years of age and advocates approaches that give every child the same chance for survival.

Dr Shigeru Omi
Regional Director
World Health Organization
Western Pacific Region

Ms Anupama Rao Singh
Regional Director
United Nations Children's Fund
East Asia and Pacific Region

Annex

1. Background

In the Region[a], it has been estimated that 3000 children under 5 years of age die every day from common preventable and treatable conditions including diarrhoea, pneumonia, and perinatal events.[1] Many of these deaths are associated with undernutrition. Vaccine preventable diseases and injuries further contribute to this high number of childhood deaths.

Most childhood deaths occur in low-income countries or poor communities in middle-income countries where many deaths are unrecorded. Six countries (Cambodia, China, the Lao People's Democratic Republic, Papua New Guinea, the Philippines and Viet Nam) account for more than 75% of all deaths among children under 5. As many as 800 000[2] children under 5 will continue to die every year in these countries if current trends continue.

Countries of the Region are committed to the development goals of the United Nations Millennium Declaration (MDG).[3] MDG4 calls for a reduction by two thirds, between 1990 and 2015, of the under-5 mortality rate. This goal is contingent on progress with other MDG, particularly MDG1 (eradicate extreme poverty and hunger) and MDG5 (improve maternal health). Few countries in the Region are on track to achieve these goals, and significant action must be taken to improve child survival and achieve MDG4.

The Convention on the Rights of the Child, ratified by all countries of the Region, and the convention's monitoring body, the United Nations Committee on the Rights of the Child, provide a valuable framework for child health. Article 6 of the Convention specifically affirms the inherent right to life of every child, and Article 24 addresses the right to health and health care.[4]

The WHO Regional Committee at its fifty-fourth session adopted resolution WPR/RC54.R9 that strongly urged that child health higher take a higher place on the Region's political, economic and health agendas and that financial resources be allocated to match the burden of childhood disease (Annex). This prompted a new drive to reduce child mortality in Member States, particularly in areas of greatest need. Action is required through resource mobilization, stronger outcome orientation, advocacy and monitoring that addresses the existing limitations in human and financial resources that currently prevent optimizing the delivery of life-saving interventions.

The renewed commitment and emphasis on childhood mortality reduction warrants a regional strategy for child survival that accommodates the most important life-saving interventions and leads to a childhood mortality reduction in the Region in line with the Millennium Development Goals. The World Health Organization (WHO) and United Nations Children's Fund (UNICEF) have joined forces to develop this strategy. The document is intended for governments of Member States, policy-makers and partner agencies.

---

[a] Region is defined as countries and areas common to the WHO Western Pacific Region and the UNICEF East Asia Region. In addition, some South Pacific island nations not covered by any UNICEF programme are included.

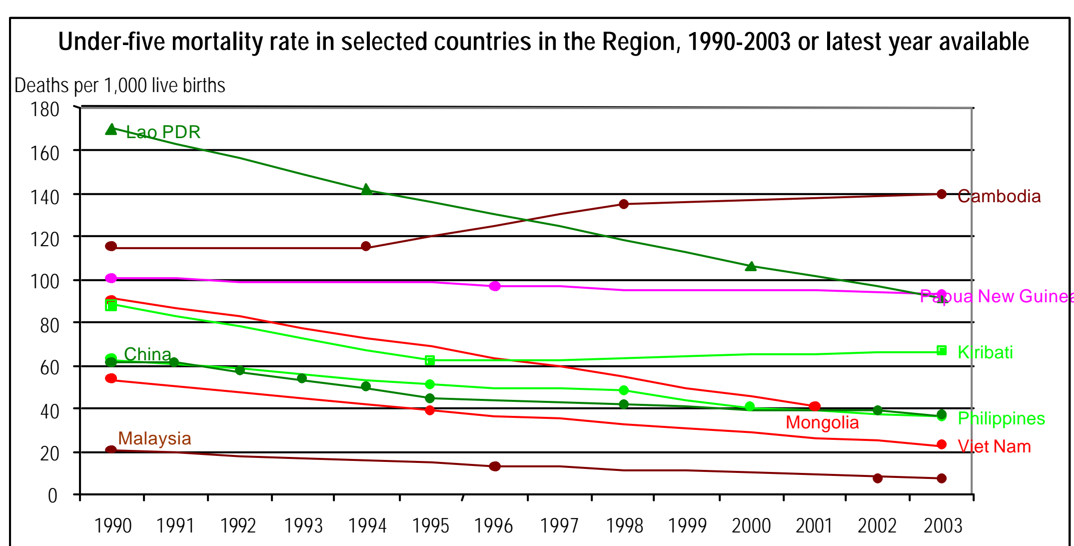
Annex

2. Rationale for accelerated and sustained action for child survival

2.1 Stagnating mortality reduction

The child survival revolution of the 1980s greatly reduced child mortality, particularly in the 1-4 year age group. Since then there has been slow reduction in child mortality and increasing evidence of disparities. The infant and under-5 mortality rates in the Region show a deceleration in improvement, with an actual worsening in some countries (Figure 1).[5] A worsening in the under-5 mortality rate (U5MR) has occurred in Cambodia since 1994. Kiribati, Papua New Guinea, and the Philippines have shown little change in the last 10 years.

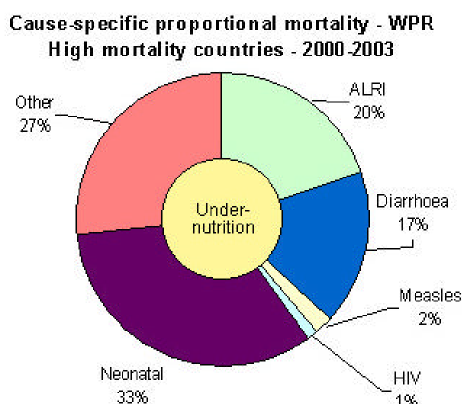
Figure 1



While cost-effective, evidence-based strategies to deliver child survival interventions have been implemented to a limited degree, they have not received due attention and the investment necessary to take them to scale.

2.2 Persistence of the major causes of childhood mortality

Figure 2



Recent child and neonatal health data from the Region on causes of death in 0-4 year old children shows a yearly average of approximately 1.02 million deaths over 2000-2003.[1] Main causes of mortality in high-mortality countries are shown in Figure 2.

Neonatal events are estimated to account for 33% of the deaths, and the proportion increases when the total under-5 mortality decreases. There is evidence at the global level that most neonatal deaths are caused by infections (36%), birth asphyxia (23%), complications of due to premature birth (28%) and congenital anomalies (8%).[6]

Acute lower respiratory infections are still the single most important cause of death (20%) among children under 5 years old, with diarrhoea a close second cause (17%).[1] Measles remains a cause of 2% of childhood deaths. Even if malaria does not amount to a high total percentage of deaths in the Region, it is a cause of high child mortality in some countries such as the Lao People's Democratic Republic [7], Papua New Guinea[8] and high-mortality provinces in Cambodia [9]. HIV/AIDS is an emerging problem in the Region and is related to about 1% of mortality among children under 5, primarily in relation to mother-to-child transmission.

Undernutrition is an underlying cause in around 50% of deaths.[1] Globally it contributes to 61% of deaths from diarrhoea, 57% from malaria, 52% from pneumonia and 45% from measles. Latest demographic and health surveys (DHS) and national statistics from countries and areas in the Region show that only 5%-23% of infants 4-6 months are reported to be exclusively breastfed in Cambodia, the Lao People's Democratic Republic and Viet Nam. Complementary foods are often introduced too early and lack nutrient density and adequate levels of micronutrients.

Maternal health and nutrition status before and around conception, as well as during pregnancy, significantly influence fetal development and the potential for survival after birth. Of the 30 000 maternal deaths every year in the Region, more than 40% occur in Cambodia, the Lao People's Democratic Republic, Papua New Guinea, the Philippines and Viet Nam.[10] The total fertility rate is still very high in some countries and areas.

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

About 20 % of the population of the Region still lacks access to safe water for drinking and food preparation, and nearly 1 billion people lack access to adequate sanitation. These factors underlie almost 90% of the deaths from diarrhoea.[11] Countries with the lowest level of access are precisely those that have the highest rates of under-5 mortality. Large disparities also persist within countries[12]. These disparities and their consequences are most severe in urban slums and in rural communities.[10]

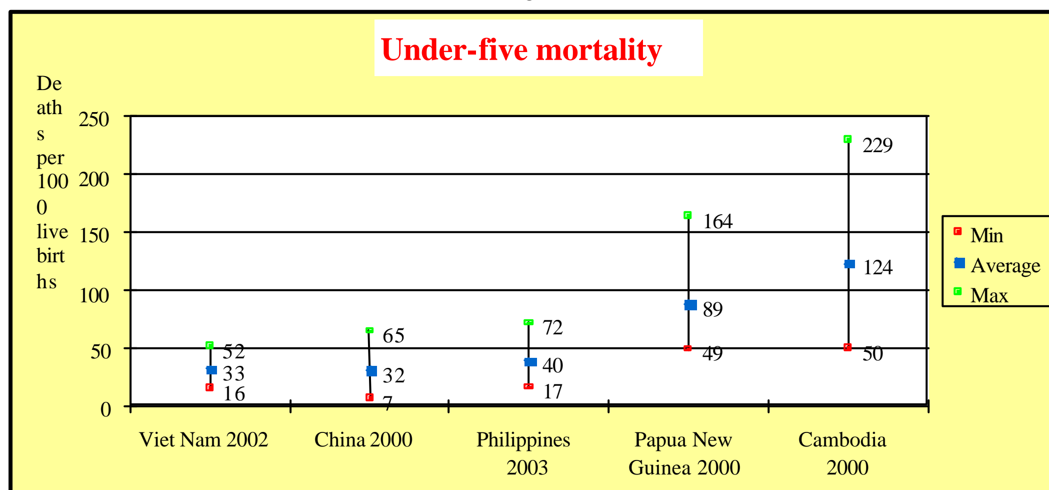
Unsafe environments that contribute to unintentional injuries, drowning, poor environmental hygiene, and indoor air pollution prevail in many parts of the Region. In countries and areas in transition, the proportion of childhood deaths due to accidents and injuries is increasing. In the WHO Western Pacific Region, for example, it is estimated that 7% of childhood deaths are caused by injury.[1]

2.3 Continued disparities

While many countries and areas in the Region are known for economic prosperity, there are enormous disparities between countries and areas reflected in the wide range of national rates of infant and under-5 mortality and undernutrition. Furthermore, analysis of some indicators suggests that the disparities are widening.[13]

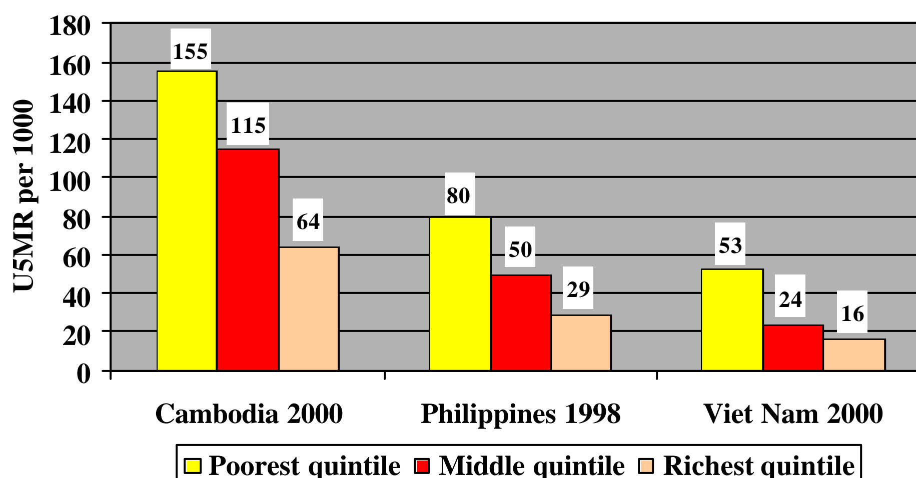
Annex

Figure 3



There are also large disparities within individual countries as shown in Figure 3, illustrating the variations in under-5 mortality in some countries of the Region.[9, 14 15 16 17] Cambodia shows the greatest variance: Phnom Penh has an U5MR of 50, while two provinces in the north-east have U5MR greater than 220.[9]

Figure 4 Under-five mortality by socioeconomic strata



The disparities are not only geographical but are also found across socio-economic strata.[18] For example, in Viet Nam the poorest quintile is reported to experience more than three times higher under-five mortality rates than the richest quintile (Figure 4).

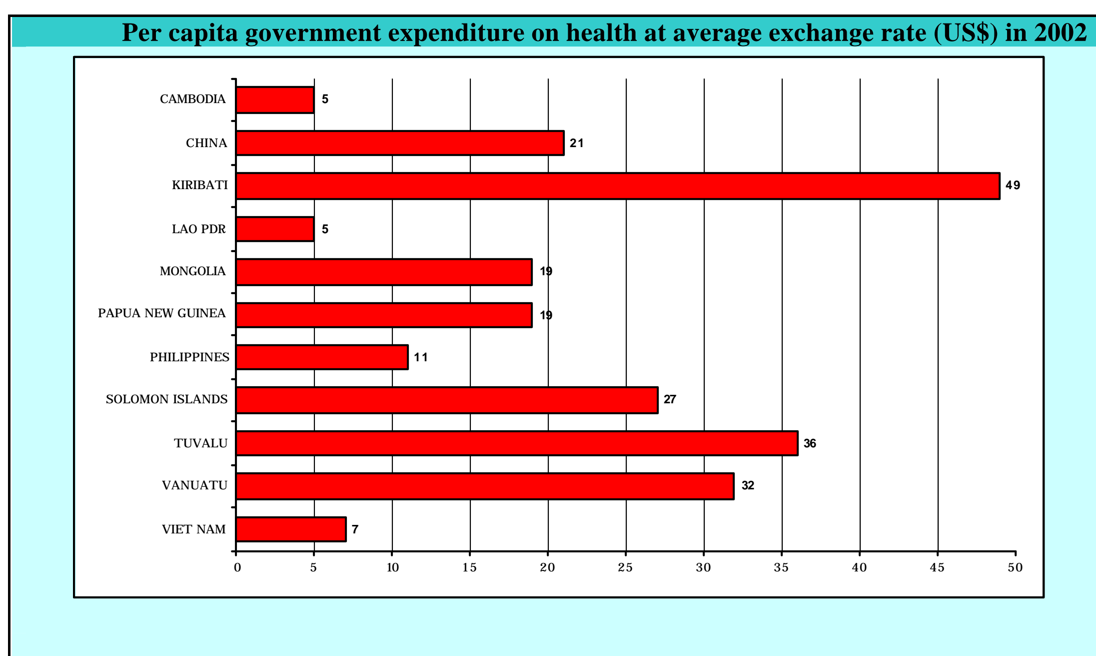
2.4 Insufficient funding for child survival

An estimated $34 per capita is required for basic health services including an essential package for child survival.[19]

Many countries and areas do not allocate enough general government resources to health; the allocation for tax revenue to health is insufficient and mechanisms such as insurance for

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

Figure 5



Many countries and areas in the Region are unable to generate sufficient resources to independently finance their health systems. Regional donors pledged to spend 0.7% of their Gross National Income on official development assistance. However, it is clear that greater efforts are needed in order to realize this commitment.[20] Donor funding for child survival is very low compared with the high number of child deaths, commitment to the MDG, a moral obligation to protect vulnerable children, and the fact that extremely cost-effective interventions exist.

2.5 Lack of coherence and visibility

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

3. Strategy overview

3.1 Goal

To reduce inequities in child survival and achieve national targets for MDG4 by accelerating and sustaining actions to reduce childhood mortality.

3.2 Objectives

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

3.3 Strategic approaches

- Improve leadership and governance;
- consolidate partnerships;
- improve efficiency and quality of service delivery;
- engage and empower families and communities; and
- ensure health care financing support for child survival.

4. Essential package for child survival

A series in *The Lancet* in 2003 extensively reviewed key child survival interventions. These articles estimated that two thirds of child deaths could be prevented by universal coverage of 23 interventions by virtue of the strength of the evidence for the effect of each on child mortality.[21] Also, 16 interventions with proven efficacy for neonatal survival were reviewed and presented in another series in 2005 in *The Lancet*.[20] In areas with high child mortality, high coverage with a selected subset of these interventions delivered through an essential package could substantially reduce neonatal and child mortality.

This strategy focuses on the implementation of an **Essential package for child survival**.

Essential package for child survival
• Skilled attendance during pregnancy, delivery and the immediate postpartum • Care of the newborn • Breastfeeding and complementary feeding • Micronutrient supplementation • Immunization of children and mothers • Integrated management of pneumonia, diarrhoea and malaria • Use of insecticide-treated bednets

Skilled attendance during pregnancy, delivery and the immediate postpartum

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

Care of the newborn

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

Breastfeeding and complementary feeding

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

Micronutrient supplementation

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

Immunization of children and mothers

Vaccinating children with measles, tetanus, diphtheria, pertussis, polio, BCG and hepatitis B vaccines are part of the routine Expanded Programme on Immunization (EPI) schedule. To protect newborns against tetanus, two doses of tetanus toxoid vaccine for the mother during her pregnancy, or five doses in her lifetime, provide the best assurance. In some countries and areas, other vaccines may be available through the routine EPI schedule. Vitamin A and deworming may also be delivered with immunization, and use of insecticide-treated bednets should be promoted during immunization sessions.

Integrated management of pneumonia, diarrhoea and malaria

Management of pneumonia, diarrhoea and malaria requires an integrated approach. A continuum of care must be emphasized where case management occurs in the community, at health facilities and at the referral level. Different combinations of interventions will be available at each delivery point. Referrals to hospitals are necessary for children with severe

pneumonia, diarrhoea and malaria. Assessing the whole child during a consultation will allow the identification of other conditions such as severe malnutrition requiring treatment and/or referrals.

Pneumonia in children requires prompt diagnosis and treatment with antibiotics. Case management of diarrhoea requires oral rehydration therapy with low-osmolarity oral rehydration salts (ORS), along with zinc. Antibiotics are indicated for dysentery only.

In malarious areas of the Region, falciparum malaria in most countries is treated with artemisinin-based combination therapies (ACT) due to high multidrug resistance. Due to the high cost of treatment with ACT, it is important that there is a blood-sample-based diagnosis with microscopy or rapid diagnostic tests. Vivax malaria can cause severe morbidity and should also be diagnosed and treated. Treatment of both falciparum and vivax malaria should follow national guidelines.

Use of insecticide-treated bednets

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

Estimated cost of main commodities for child survival

- Breastmilk is free
- 10¢ for all the Vitamin A supplements required in childhood
- $15-$17 to immunize a child against seven major childhood diseases
- 30¢ for a five-day course of oral antibiotics for pneumonia
- $3-$6 for a long-lasting impregnated bednet to prevent malaria
- 50¢ for 10 packets of ORS to prevent dehydration in children with diarrhoea, and 20¢ for a ten-day treatment with zinc

5. Contributing actions for child survival that strengthen the impact of the essential package

5.1 Improvements in water, sanitation and the environment

Increased access to safe water supply with increased quantity of water for personal and environmental hygiene and improved sanitation with safe disposal of faeces are included in MDG7 and are important to realize MDG 4. Additional actions to create safe home and community environments, clean air free from indoor and outdoor air pollution (including solid fuel use), and safe food will augment the essential package for child survival.

5.2 Birth spacing

An estimated 38% of all pregnancies occurring globally each year are unintended, and more than one half of such pregnancies result in induced abortions.[22] Families require access to good reproductive health care as evidence has shown the negative impact of short preceding birth intervals on infant mortality.[23] Children born three to five years after a previous birth are about 2.5 times more likely to survive their infancy than children born earlier.[24]

5.3 Promoting gender equality, empowerment of women and women's education

Gender gaps are widespread in access to and control of resources, as well as in economic opportunities, power and political voice. Promoting gender equality is an important part of any development strategy that enables both women and men to escape poverty and improve their standard of living. Economic development paves the way for increasing gender equality over the longer term. However, this must be coupled with an environment that provides equal opportunities for women and men, and policy measures that address persistent inequities. Evidence has shown that empowering women through education is likely to benefit the health of their children.[25]

5.4 Prevention of mother-to-child transmission of HIV

Most countries and areas in the Region have an increasing problem with HIV/AIDS. The countries and areas with a high prevalence should prioritize prevention of mother-to-child transmission (PMTCT) of HIV, including primary prevention, voluntary counselling, and testing, care and support for HIV-positive mothers. In areas where HIV is a significant public health problem all women must be assured access to confidential testing for HIV. If a mother is HIV-infected and replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life.[26] Drug treatment for PMTCT of HIV may be available in some countries and areas in the Region.

6. Strategic approaches for child survival

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

6.1 Improving leadership and governance

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

Accelerated action may necessitate changes in policy, laws and regulations and will require clear guidance across all relevant sectors. Ensuring that responsibilities are assumed and acted upon will require good governance[27] that involves national assemblies, ministries of

finance, planning and investment, education, agriculture, labour, justice and social affairs, as well as local governments and state-run media. Non-governmental institutions such as political parties, the media, professional associations, religious leaders, rural cooperatives, community-based organizations, civil society organizations and the private sector each play complementary roles.

A high-level national body should coordinate planning for child survival actions. Not only will this approach promote improved coordination between various Ministry of Health departments, such as maternal and child health, communicable diseases, nutrition, and human resources but also with all relevant stakeholders from other governmental sectors including finance, education, agriculture and legislative.

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

6.2 Consolidating partnerships

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

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

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

The Partnership for Maternal, Neonatal and Child Health[28] has been established at the global level. In certain countries and it may be useful to call on the support of this partnership to bring greater attention to the need for increased resources and action for child survival.

6.3 Improving efficiency and quality of service delivery

The approach taken to achieving accelerated and sustained action towards MDG4 will depend on the capacities of health systems. It should exploit all available delivery points for child survival interventions at various levels. In the community, these include commodity retailers, pharmacies, drug sellers, community health workers and outreach services. Some interventions can only be delivered through outpatient and inpatient health facilities. The public, charitable or for-profit private sectors can all provide services.

6.3.1 Delivering essential interventions at the community level

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

Community-level case management of uncomplicated pneumonia, diarrhoea, malaria and neonatal sepsis has proven to be feasible and effective in reducing mortality.[29] [30] This requires community health workers who are formally authorized to carry out these tasks, adequately trained and supervised. Use of antimicrobial drugs at this level may require programmatic and legislative changes. If community health workers are used, thorough planning is required for their training, recruitment, placement, supervision and motivation. Delivery of child survival interventions through the private sector, including social marketing, also requires a clear supportive regulatory framework.

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

6.3.2 Service delivery at the health facility level

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

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

The essential child survival interventions should be promoted and delivered through integrated approaches. These include the Integrated Management of Childhood Illness (IMCI) and Making Pregnancy Safer (MPS) through the Integrated Management of Pregnancy and Childbirth (IMPAC) and the Infant and Young Child Feeding (IYCF) strategy. Integrated case management approaches are not only cost-effective but also reflect best clinical practice. IMCI has been shown to improve quality of care and increase utilization of health facilities and impact.[31]

Hospital-level approaches to implementing elements of the essential child survival interventions include the Baby Friendly Hospital Initiative and guidelines and activities to

improve the quality of hospital paediatric care. These strategies need to be strengthened and pursued.

6.4 Engaging and empowering families and communities

The potential of family and community practices to improve child survival has been well demonstrated.[30] Most of the care of childhood illness occurs in the home; to improve this care families may need to change their behaviours. Though difficult, this can be accomplished by repeatedly providing information, education and communication to families through different channels including mass media, community and religious leaders, and health workers. Improving health worker skills in counseling and working with peer-educators and community groups are essential. Coordinated efforts with these partners can help ensure consistency of messages.

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

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

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

Sustainable change in family practices will be more likely when communities are actively involved in the planning, implementation and monitoring of health promotion and health care activities.[32]

The Integrated Early Childhood Development (IECD) strategy promoted by UNICEF is one approach to ensure all elements of community action for child survival, growth and development are put in place together.

6.5 Ensuring health care financing support for child survival

Actions to increase budgetary spending for health by 1% of GNP by 2007 and 2% of GNP by 2015 compared with levels of spending in 2001 in low- and middle-income countries[19] should be pursued as part of a comprehensive national policy on health care financing. Health care financing mechanisms that aim to reduce financial barriers to health care support the right of every child to health and health care.

It is important that child survival interventions funded by different financial mechanisms should increase the utilization of the essential package. Broadly speaking, these mechanisms include tax-based systems, social health insurance, private health insurance including community-based health insurance, or mixes of these. The objectives of equity and pro-poor financing should guide the design of the social protection schemes selected. Policy-makers should aim at including children among the direct beneficiaries in these schemes. Key child

survival interventions should be included in the essential package of health services guaranteed to the population. This may be particularly relevant in poorer populations. One should also aim that the essential package of child survival interventions should be free of any charges at the point of use. Subsidizing the production and sales of commodities with high child survival impact, such as bednets, ORS and fortified food should also be considered. An important outcome may be life-saving and timely care seeking for childhood illnesses.

The government stewardship role needs to be strengthened to use all available resources including government and nongovernmental sources effectively for enhancing child survival. Child health should also be incorporated as a priority within Poverty Reduction Strategies, Medium-Term Expenditure Frameworks, Sector-Wide Approaches, Socio-Economic Development Plans and other planning, financing and coordination instruments. These increasingly guide national poverty reduction and development efforts and external financing.[33]

7. Addressing diversity and inequity across and within countries

7.1 Diversity of countries and areas in the Region

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

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

Figure 6. Category of countries in relation to child survival

Annex

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

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

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

Table 1. Child survival actions by country group

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

7.2 Addressing inequity

This strategy aims to accelerate and sustain action towards reaching MDG4 by implementing an essential package for child survival with universal coverage[34]. The strategy will be successful in reducing inequity only if interventions reach the poorest and most marginalized households of all countries of the Region. This includes those marginalized by geographical, social, political, economic, ethnic and gender factors.

Achieving universal coverage of the essential package is a considerable challenge and takes time.[34] In Group 1 countries where most households have a low income, achieving universal coverage of the essential package will reduce inequities in child survival. Because overall coverage levels in these countries are low, there is no point in targeting interventions at this point. On the other hand, targeting of the poor households in Group 2 and Group 3 countries and areas is recommended while striving for universal coverage for all children. If pro-poor approaches are used they need to be implemented at high coverage to be most successful.

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

8. Monitoring and evaluation of child survival activities

8.1 Monitoring implementation

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

Table 2 Ten core indicators for child survival[b]

	Components of essential package	Core indicators
1	Skilled attendance during pregnancy, delivery and the immediate postpartum	1. Proportion of deliveries assisted by a skilled birth attendant
2	Care of the newborn	2. Proportion of infants with breastfeeding initiated within one hour of birth
3	Breastfeeding and complementary feeding	3. Proportion of infants exclusively breastfed for the first 6 months 4. Proportion of infants 6-9 months old receiving breastmilk and semi-solid foods in the past 24 hours
4	Micronutrient supplementation	5. Proportion of children 12-59 months old who have received vitamin A in the past 6 months
5	Immunization of children and mothers	6. Proportion of children 12-23 months old immunized against measles before reaching 12 months of age 7. Proportion of pregnant women who have received 2 doses of tetanus toxoid during their most recent pregnancy or 5 doses in their lifetime
6	Integrated management of diarrhoea, pneumonia and malaria	8. Proportion of children with diarrhoea in the past 2 weeks that received ORT 9. Proportion of children with cough and fast or difficult breathing in the past 2 weeks who received treatment
7	Use of insecticide-treated bednets	10. Proportion of children less than 5 years who slept under an insecticide-treated bednet the previous night

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

In addition to monitoring the implementation of interventions, it is important to measure resource flows to child survival activities and the impact of health financing mechanisms. The amount and proportion of government health spending on child health should be

---

[b] WHO and UNICEF at the global level are working towards interagency consensus on a minimal set of key indicators for monitoring progress towards child survival. This global list is to be reviewed in December 2005. The 10 core indicators for child survival are in agreement with the current list.

monitored annually. Similarly, the cost to the health system and to families of the key interventions should be monitored to ensure that they remain affordable to those who need them. The analysis of monitoring results should include both health indicators and financing indicators.

8.2 Evaluation

Periodic evaluations, every five years or more frequently, of the status and impact of child health interventions on mortality, undernutrition and equity should be conducted. This requires large-scale population based surveys, such as DHS or MICS that have the capacity to measure the MDG and other indicators, including under-5 infant and neonatal mortality rates, underweight and stunting, in addition to the 10 core indicators and other standard indicators routinely included in these surveys. Surveys should be complemented by programme reviews that identify best practices, as well as constraints and ways to overcome them. When possible the surveys and reviews should be performed in collaboration with independent third-party institutions.

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

9. The way forward: organize and mobilize

"The Three Ones, Plus Two"

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

9.1 One coordination mechanism

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

9.2 One national plan

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

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

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

9.3 One monitoring and evaluation process

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

9.4 Mobilize for advocacy and communication

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

In order for this to happen each country should prepare a child survival advocacy plan and ensure that resources are devoted to implementing it. This may be a critical first step in drawing further resources to child survival efforts.

9.5 Mobilize financial resources to accelerate and sustain progress

To achieve MDG4 in the Region massively increased investments in child health will be required through increased government spending and external assistance. To achieve and sustain adequate and stable financing for child health, there needs to be stronger political commitment to increased government resource allocation. In some countries, however, it is not realistic to think that the considerable additional needs can be met within the government health budget. For the poorer countries of the Region, only a significant increase in external funding will achieve the increase in effort needed.

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

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

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

Monitoring the first steps

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

References

[1] Bryce J, Boschi-Pinto C, Shibuya K, Black R and the WHO Child Health Epidemiology Reference Group. WHO estimates of the causes of death in children. *Lancet* 2005; **365**: 1147-52

[2] Estimates based on data in WPR Country Health Information Profiles 2004

[3] UN Millennium Summit: Goals of the Millennium Declaration. September 2000

[4] The Convention on the Rights of the Child (http://www.unhchr.ch/html/menu2/6/crc/treaties/crc.htm)

[5] UNICEF. *The State of the World's Children*. 2005 and previous issues

[6] Lawn JE, Cousens S, Zupan J. 4 million neonatal deaths: when? where? why? *Lancet* March 2005 (Neonatal Survival Series)

[7] Summary Report of Provincial Data Analysis. Lao Reproductive Health Survey 2000

[8] PNG Country Profile – data based on: Census and national health information data reported by National Department of Health Child Health Unit

[9] National Institute of Statistics/Directorate General for Health. Cambodia Demographic and Health Survey 2000

[10] Maternal mortality 2000. WHO, UNICEF, UNFPA

[11] Ezzati M et al and the Comparative Risk Assessment Collaborating Group. Selected major risk factors and global and regional burden of disease. *Lancet* 2002; **360:** 1347-60

[12] WHO / UNICEF. Joint Monitoring Programme for Water Supply and Sanitation Coverage Estimates Improved Drinking Water. Updated in July 2004

[13] C Victora, A Wagstaff, J Armstrong Schellenberg, D Gwatkin, M Claeson, J-P Habicht. Applying an equity lens to child health and mortality: more of the same is not enough. *Lancet* 2003; **362**: 233-41

[14] Viet Nam Demographic and Health Survey 2002

[15] National Programme of Action. Provincial Working Committees on Children/Provincial Bureau of Statistics. Provincial Reports on Indicators of NPA Goals. People's Republic of China 2001

[16] Philippines Demographic and Health Survey 2003

[17] National Statistical Office 2000 Census: Recent Fertility and Mortality Indices and Trends in Papua New Guinea. April 2003

[18] Gwatkin D et al. In Carr D. Improving the health of the world's poorest people. Washington D.C., Population Reference Bureau, 2004 (Health Bulletin 1)

[19] *Macroeconomic and Health: Investing in health for economic development*. Report of the Commission on Macroeconomics and Health, WHO, 2001

[20] Newborn health: a key to child survival. *Lancet* 2005

[21] The Bellagio Child Survival Group. *Lancet* 2003

Annex

[22] The Alan Guttmacher Institute. Sharing Responsibility: Women, Society and Abortion Worldwide, 1999

[23] Whitworth A, Stephenson R. Birth spacing, sibling rivalry and child mortality in India. *Social Science and Medicine* 2002; **55**: 2107-2119.

[24] Population Reports 2002 Summer; (13): 1-23

[25] The International Bank for Reconstruction and Development. A World Bank Policy Research Report. Summary Gendering Development 2001

[26] WHO/UNICEF/UNFPA/UNAIDS. HIV transmission through breastfeeding: review of available evidence. 2004. WHO, Geneva

[27] http://www.unescap.org/huset/gg/governance.htm What is good governance?

[28] Description titled: "The Global Child Survival Partnership: a new initiative to save children's lives". Available at CAH/WHO website

[29] Family and community practices that promote child survival, growth and development: A review of the evidence. Geneva, World Health Organization 2004

[30] Sazawal S and Black RE. Effect of pneumonia case management on mortality in neonates, infants and pre-school children: A meta-analysis of community based trials. The Lancet Infectious Diseases, vol. 3, no. 9, September 2003, pp. 547-556

[31] The Multi-country Evaluation of IMCI Effectiveness, Cost and Impact. MCE progress report, May 2002 - April 2003, Geneva: Department of Child and Adolescent Health and Development, World Health Organization, August 2003. WHO Document No. WHO/FCH/CAH/03.5

[32] Claeson M, Waldman RJ. The evolution of child health programmes in developing countries: from targeting disease to targeting people. Bull WHO 2000, 78(10):1234-1245

[33] World Bank PRSP website: http://www.worldbank.org/participation/PRSP/PRSP.htm

[34] The World Health Report 2005. Making every mother and child count. WHO 2005

APPENDIX

WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTE

R E S O L U T I O N

REGIONAL COMMITTEE FOR THE WESTERN PACIFIC

COMITE REGIONAL DU PACIFIQUE OCCIDENTAL

WPR/RC54.R9
12 September 2003

CHILD HEALTH

The Regional Committee,

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

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

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

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

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

…/

Annex

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

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

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

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

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

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

Appreciating the progress made so far in implementing IMCI in the Region and the urgent need to scale-up interventions in order to achieve the desired child health outcomes;

1. URGES Member States, in particular those with high child mortality:

(1) to place child health higher on their political, economic and health agendas, to protect every child's inherent right to life, and to ensure the provision of health care and medical assistance to all children in need;

…/

(2) to target child survival interventions on geographical areas and segments of society with the highest burden of childhood mortality and morbidity;

(3) in countries implementing IMCI, to prioritize, strengthen and scale-up implementation of the strategy and, utilizing all available sources of finance, to provide adequate human and financial resources for the full implementation of IMCI;

(4) to strengthen national health systems and service delivery, and, where appropriate, to include IMCI in ongoing and planned health sector reform efforts;

(5) to designate, where appropriate, a national coordinating body responsible for planning, implementation, monitoring and evaluation of child health activities, including IMCI;

2. REQUESTS the Regional Director:

(1) to continue to support Member States to achieve internationally agreed goals and targets for the reduction of under five mortality, especially in countries and areas with marginalized and poor populations with high infant and under-five mortality;

(2) to develop indicators to assist Member States to monitor progress towards the achievement of the development goals of the United Nations Millennium Declaration;

(3) to give priority to child survival and, in particular, to intensify implementation of IMCI in the Region;

(4) to promote collaboration among child-health-related programmes and partners in health;

…/

Annex

(5) to stimulate the development of health care delivery strategies that are consistent with IMCI to improve the health of newborns;

(6) to lead a new drive to reduce childhood mortality in Member States in greatest need, to support these countries to mobilize the resources needed, and to report on progress to the Regional Committee.

Ninth meeting, 12 September 2003
WPR/RC54/SR/9