The State of the World's Children 2008

Themes

Child Survival: Where we stand

Lessons learned from evolving health-care systems and practices

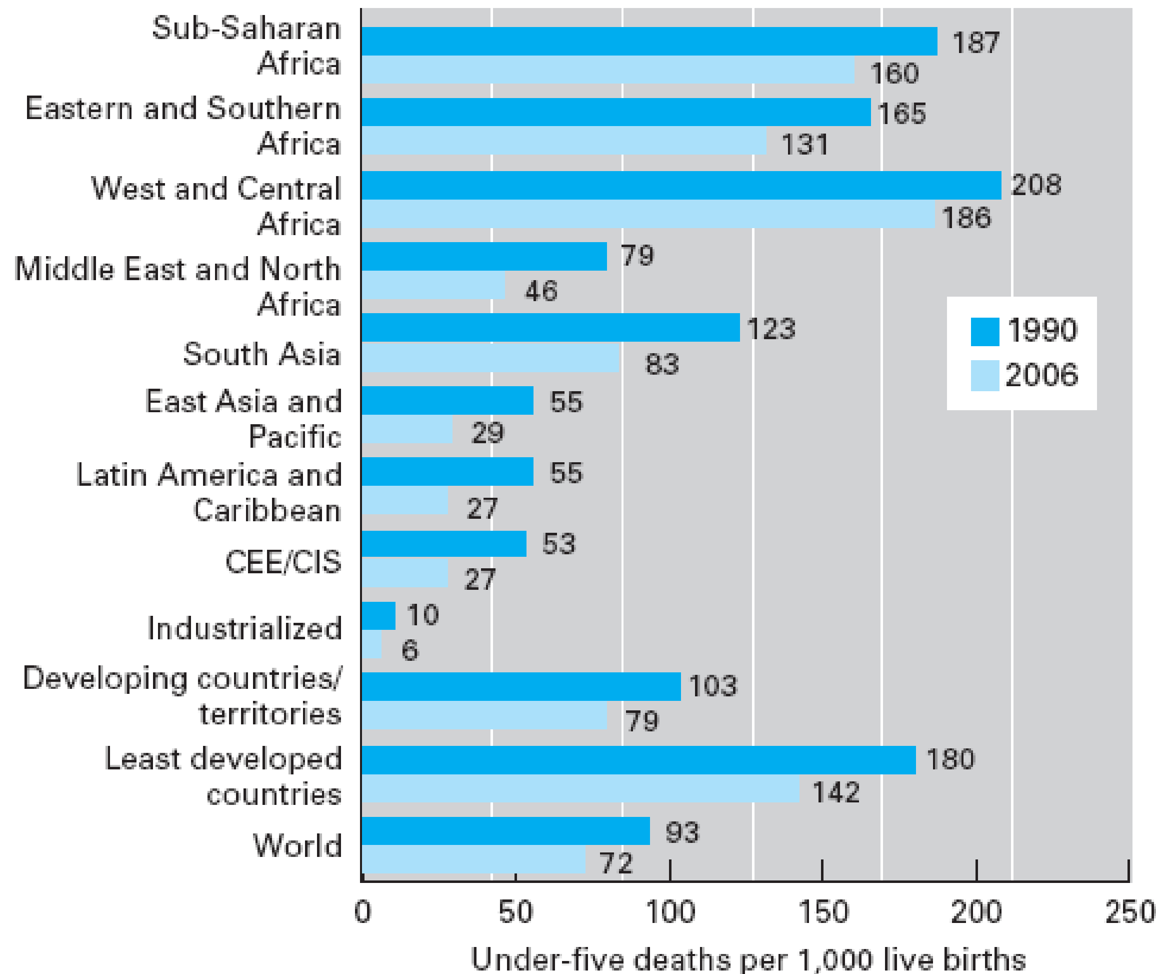
Community partnerships in primary health care for mothers, newborns and children

Strengthening community partnerships, the continuum of care, and health systems at scale

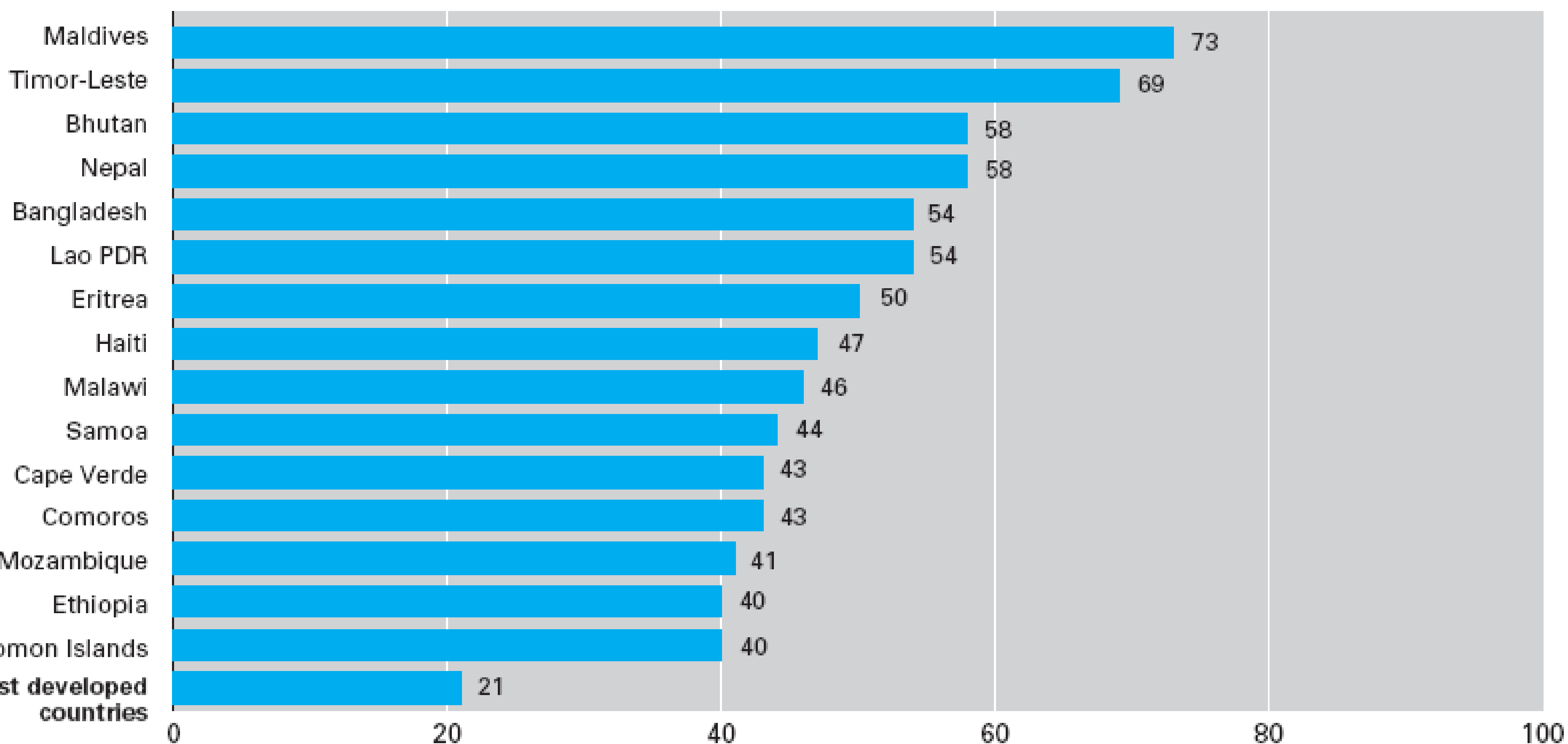
Uniting for child survival

I. Where We Stand on Child Survival

U5MR declined ¼ between 1990 & 2006



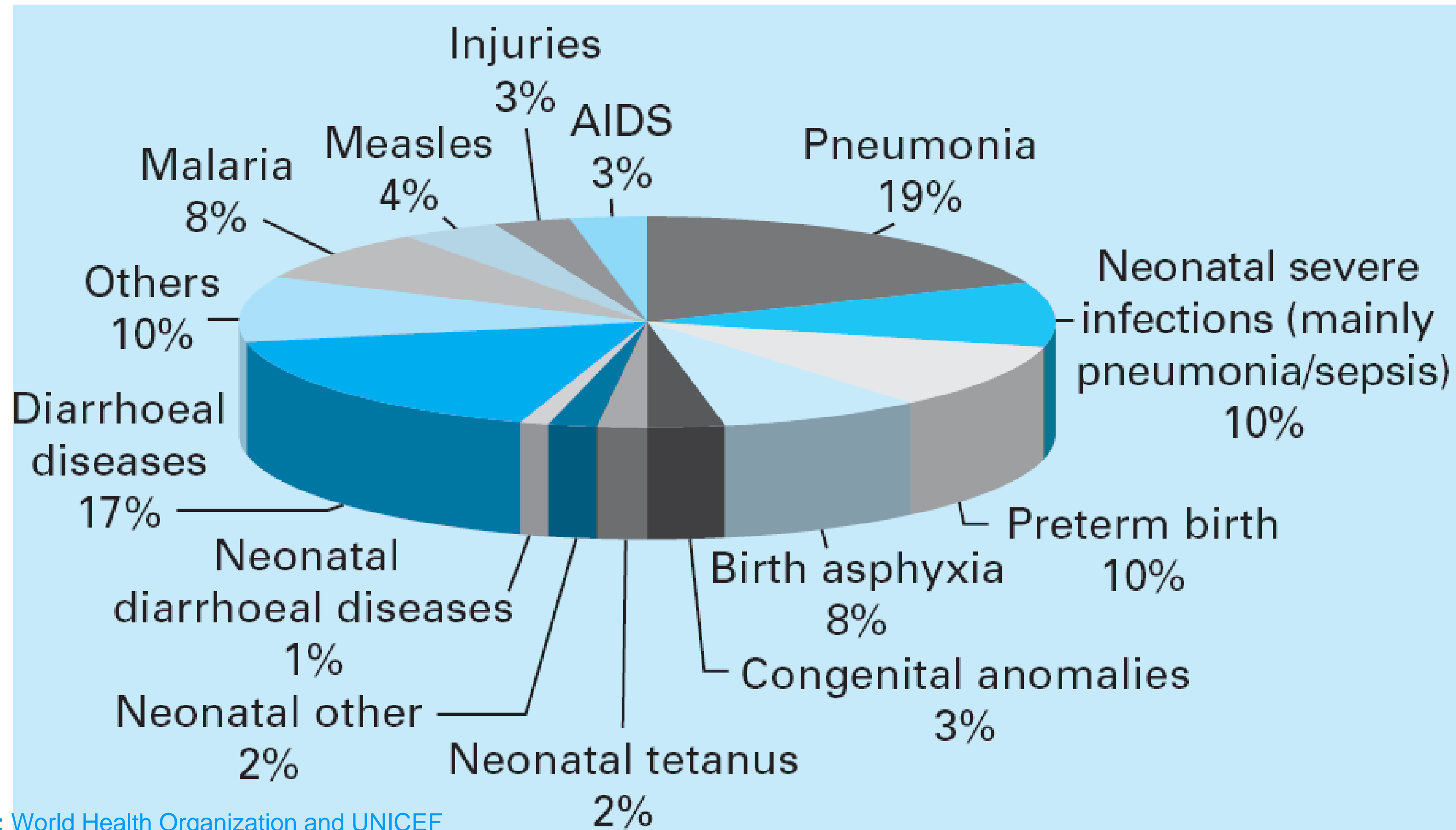
Almost 1/3 of the 50 least developed countries have reduced their U5MR by 40% or more since 1990



Source: UNICEF, WHO, UN Population Division and United Nations Statistics Division

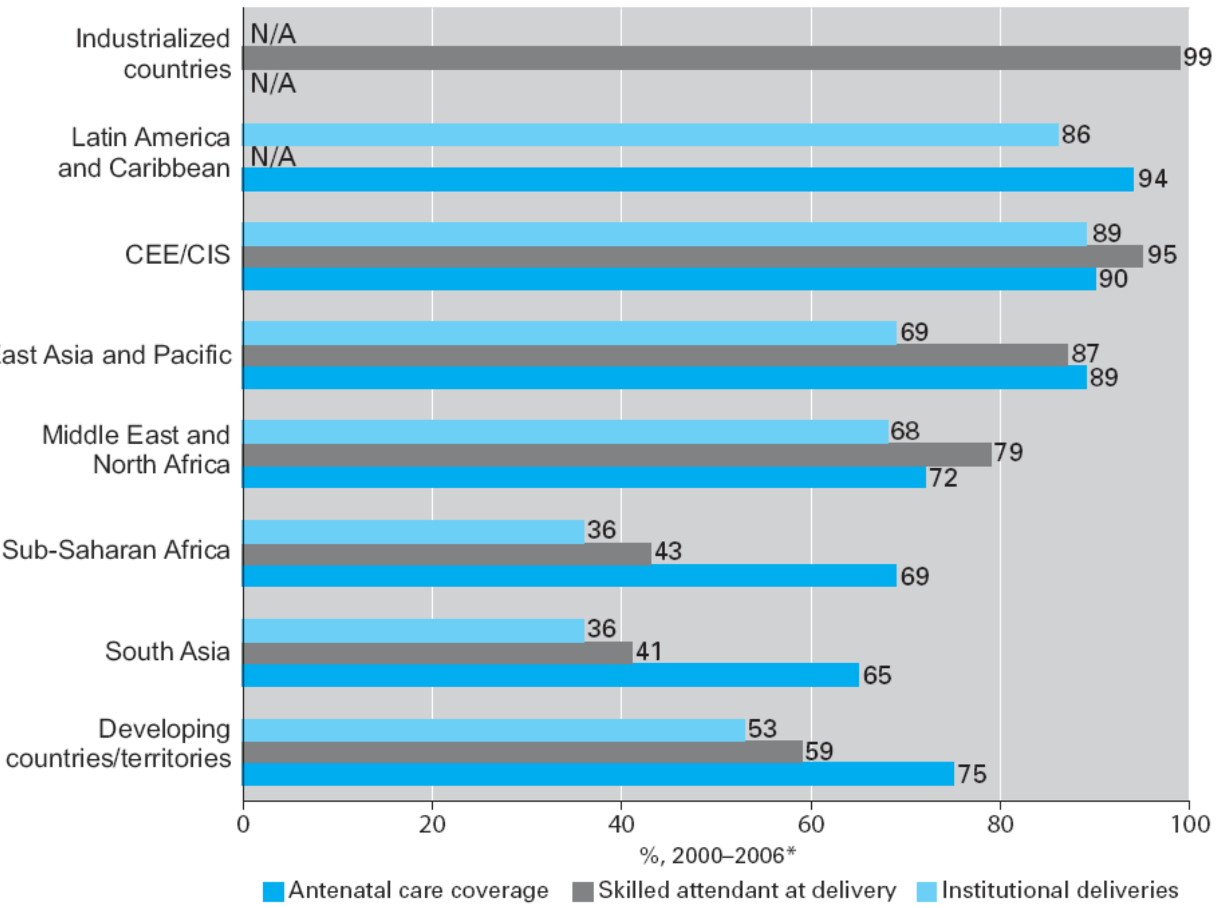
Global distribution of cause-specific mortality among children under five

Undernutrition is implicated in up to 50% of all deaths of children under five



Source: World Health Organization and UNICEF

Where We Stand on Maternal Mortality: *hi*gh rates in South Asia and Sub-Saharan Africa



Antenatal care coverage – Percentage of women 15-49 years old attended at least once during pregnancy by skilled health personnel (doctors, nurses or midwives).

Skilled attendant at delivery – Percentage of births attended by skilled health personnel (doctors, nurses or midwives).

Institutional deliveries – Percentage of women 15-49 years old who gave birth in the two years preceding the survey and delivered in a health facility.

* Data refer to the most recent year available in the period specified

Where We Stand on Malnutrition:
South Asia and Africa have highest levels

Region	%
South Asia	42
Sub-Saharan Africa	28
Middle East and North Africa	17
East Asia and Pacific	14
Latin America and Caribbean	7
CEE/CIS	5
Least developed countries/territories	35
Developing countries/territories	26
World	25

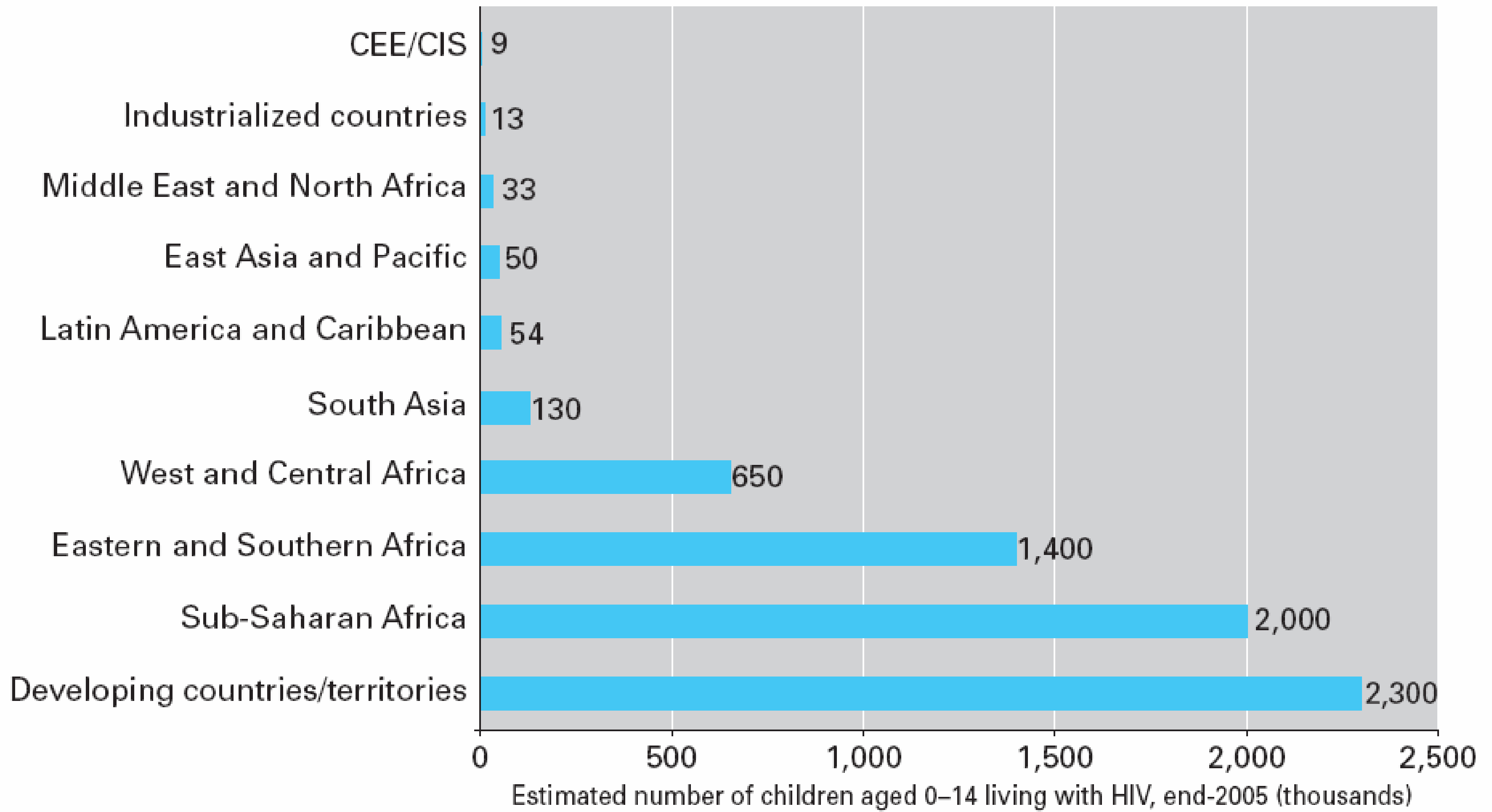
0 5 10 15 20 25 30 35 40 45

% of under-fives who are moderately or severely underweight, 2000–2006*

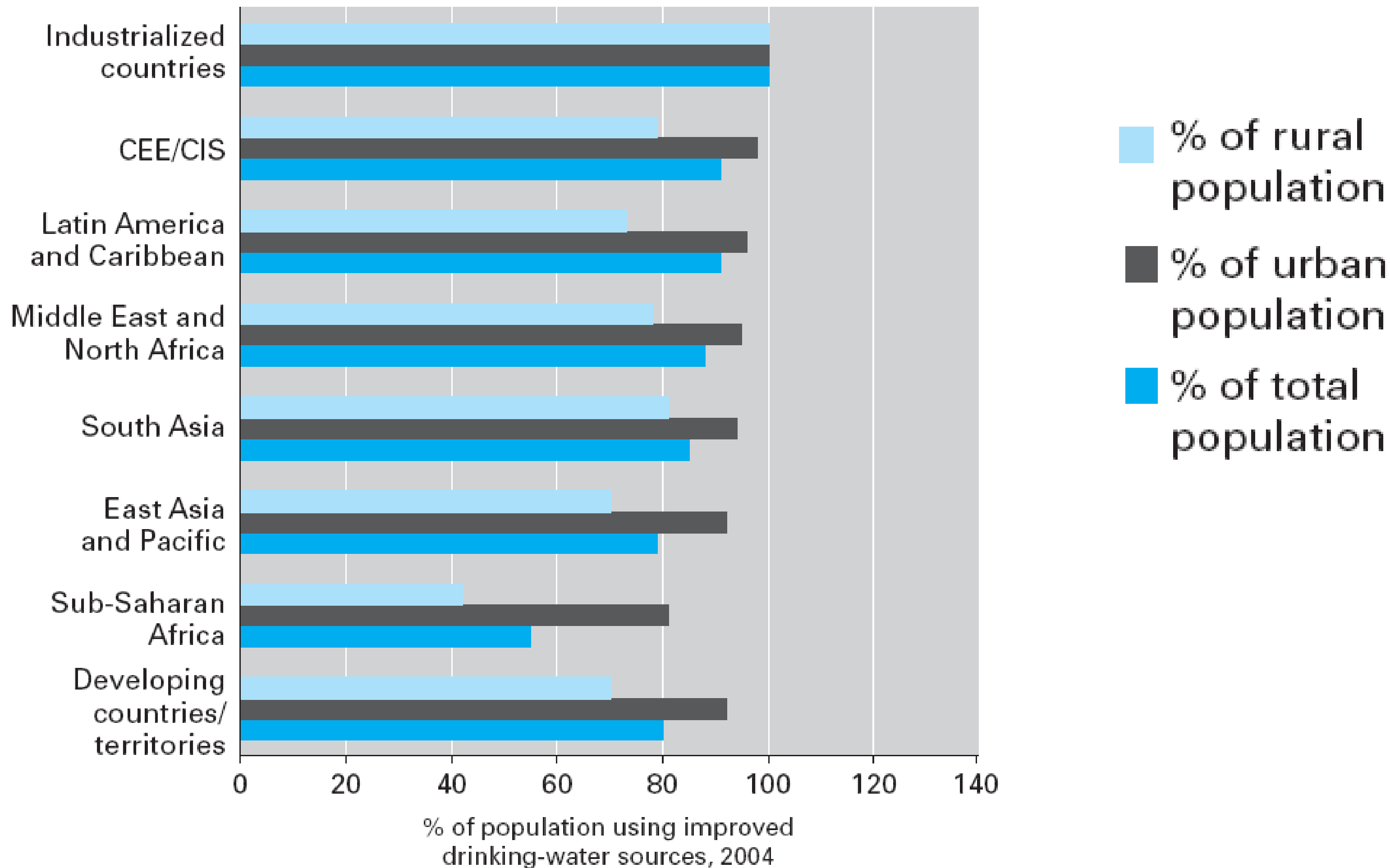
*Data refer to the most recent year available during the period specified.

Source: Demographic and Health Surveys, Multiple Indicator Cluster Surveys, World Health Organization and UNICEF. Country and regional data can be found in Statistical Table 2, p. 118 of this report.

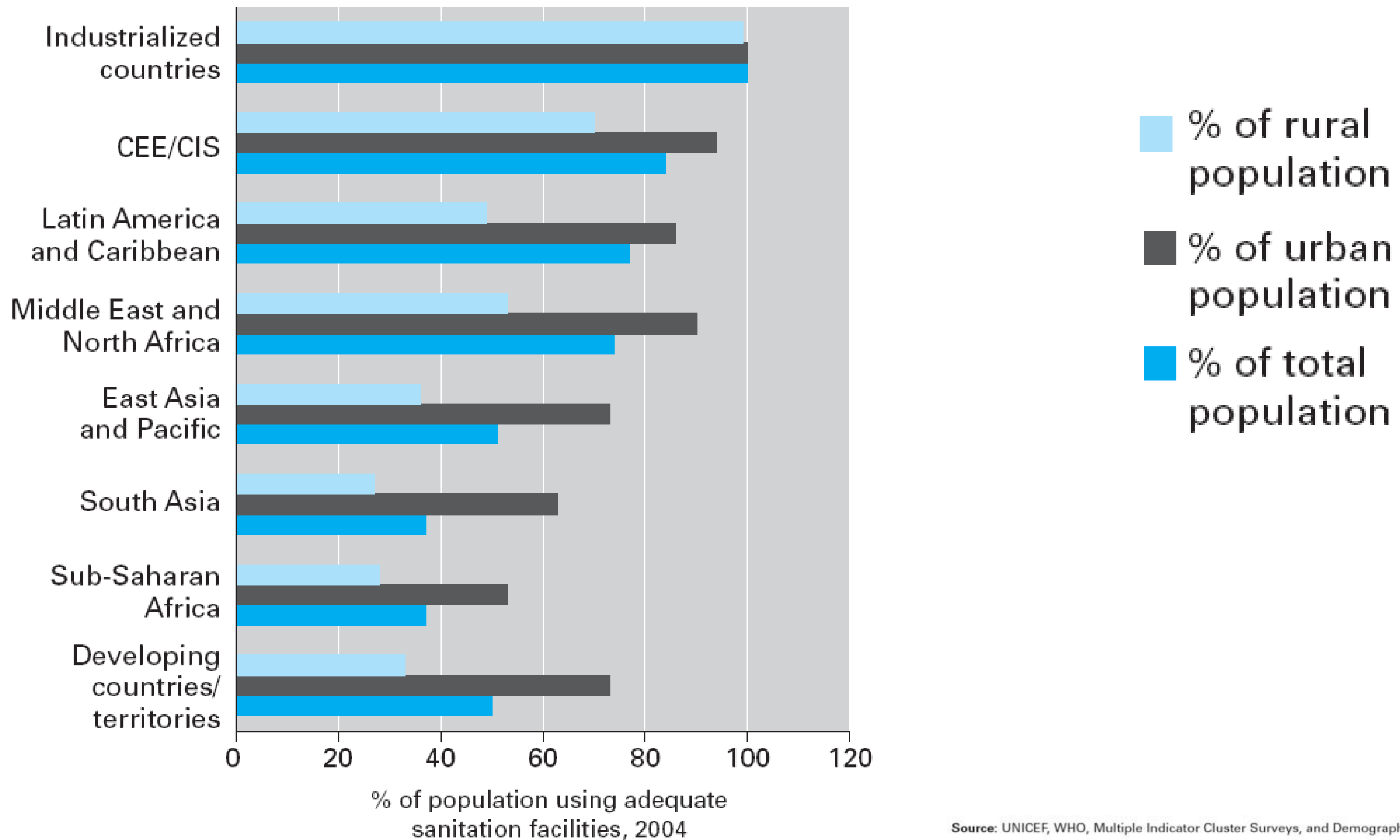
Where We Stand on HIV/AIDS: Sub-Saharan Africa accounts for 90% of paediatric HIV infections



Where We Stand on Water: 80% of developing world has access to improved sources



Where We Stand on Sanitation: half of the population in developing world has access

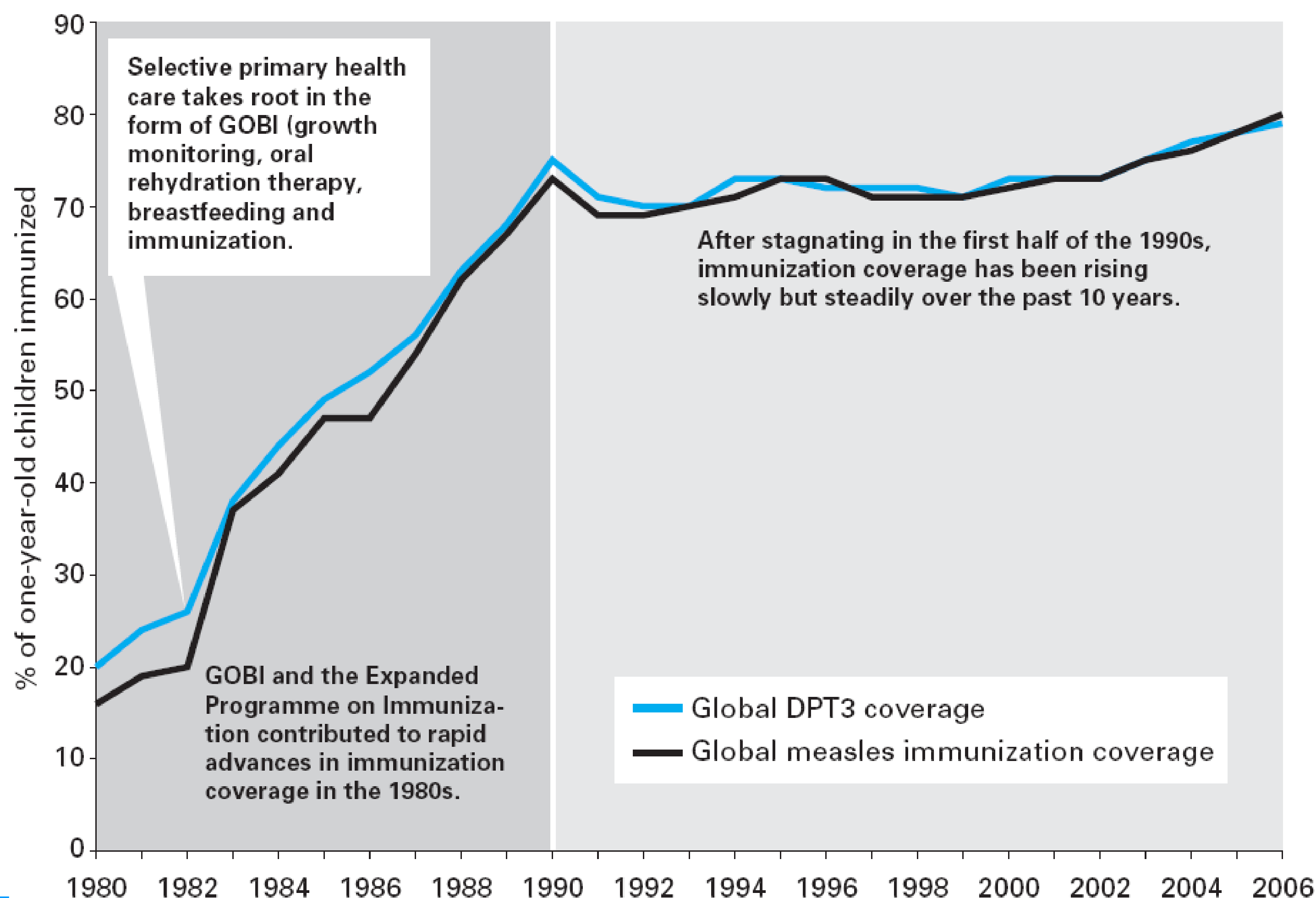


Source: UNICEF, WHO, Multiple Indicator Cluster Surveys, and Demographic and Health Surveys.

II. Lessons learned from evolving health-care systems & practices

- The colonial period (1900 – 1950's)
- Mass disease control campaigns (1950's)
- Primary health care (1978)
- Selective primary care and the child survival revolution (1980s)
- Focusing on integrated, sector-wide approaches and health systems (1990s)
- The MDGs and results-based approaches (2000 and beyond)

Selective primary health care and trends in immunization rates since 1980



Source: UNICEF

The Bamako Initiative

- Launched by African health Ministers in 1987
- Built on 5 years operations research in Benin (Pahou) and Congo (Kasongo)
- Community movement: Community co-managed, cost shared and monitored revitalization of 10.000 health centers with drug revolving funds
- Community Based National Health Systems in Benin, Guinea, Mali, DR Congo, Guinea Bissau
- Benin Immmization Coverage from 12% in 1986 to 75 % in 1990 and fully sustained since then
- Resiliance demonstrated during Togo, DR Congo, Guinea Bissau and other crisis
- Foundation for success of ACSD (10-20% U5MR reduction for $ 500/life saved)

ACSD Estimated U5MR Reductions 2002-4

ABOVE 15% U5MR REDUCTION GOAL	SENEGAL	25%
	MALI	21%
	SENEGAL EXPANSION	18%
	GHANA	17%
	BENIN	16%
BETWEEN 10 AND 15% U5MR REDUCTION	GUINEA BISSAU	14%
	GUINEA CONAKRY	12%
	BURKINA	10%
BELOW 10% U5MR REDUCTION	CHAD	10%
	BENIN EXPANSION	11%
	MALI EXPANSION	9%
	GAMBIA	9%
	NIGER	9%
	CAMEROON	5%
	GHANA EXPANSION	3%

Lessons Learned from a hundred years

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

- Ensuring a continuum of care by delivering integrated packages of health, nutrition, HIV, water and sanitation interventions will be critical to achieving maximal impact on maternal, newborn and child survival.

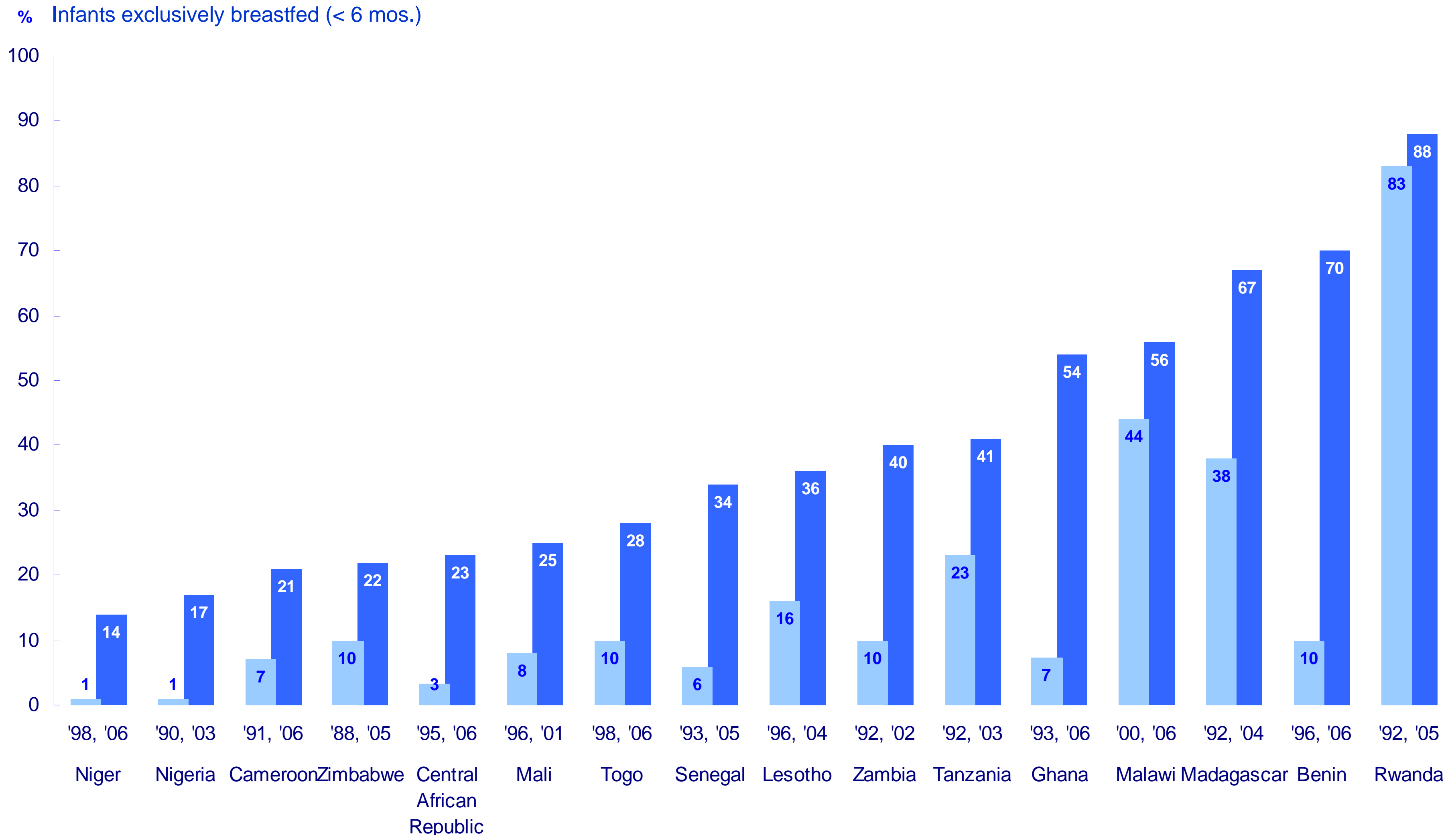
- Strengthening of 'health-systems for outcomes' combines the strength of selective/vertical approaches and comprehensive/horizontal approaches to scaling up evidence-based, high-impact intervention packages and practices, while removing system-wide bottlenecks to health care provision and usage.

III. Community partnerships in PHC: Ways of enhancing success

- Cohesive, inclusive participation;
- Support and incentives for workers;
- Adequate programme supervision and support;
- Effective referral systems to facility-based care;
- Intersectoral collaboration;
- Secure financing; and
- Integration of community partnerships with district and national health programmes and policies.

Striking increases in exclusive breastfeeding in 16 Sub-Saharan African countries

Seven Sub-Saharan African countries have achieved increases of more than 20 percentage points over the past 15 years.



Source: UNICEF global database, 2007

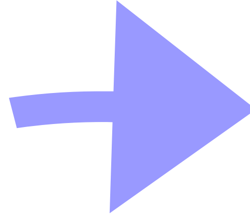
IV. Scaling up community partnerships, a continuum of care, health systems for outcomes

- Realign programmes from disease –specific interventions to evidence-based, high-impact, integrated packages to ensure a continuum of care
- Make MNCH a central tenet of integrated results based national planning processes for scaling up
- Improve the quality and consistency of financing for strengthening health systems
- Foster and sustain political commitments, national and international leadership an sustained financing to develop health systems
- Create conditions for greater harmonization of global health programmes and partnerships

Marginal Budgeting for Bottlenecks

Step 1
Health systems and high impact interventions

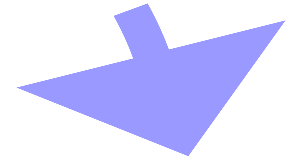
- Analyze health systems.
- Identify major U5MR,NNMR,MMR causes
- Identify high impact health, nutrition, AIDS, malaria, interventions (level 1 - 2 evidence).
- Organize interventions into **3** service delivery modes. Family oriented community based; population oriented schedulable; and individual oriented clinical services.
- Select representative tracer interventions for each sub-package of interventions.



Step 2
Systemic bottlenecks to coverage

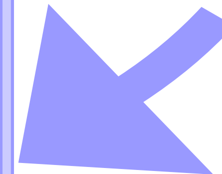
- Analyze household surveys and service statistics, using **six** coverage determinants, to identify systemic bottlenecks to coverage and causes.
- **Supply side**: availability of essential commodities, availability of human resources, physical access; **demand side**: initial and timely continuous utilization; **Effective quality coverage** .

Analyze strategies to address bottlenecks as well as set new coverage frontiers.



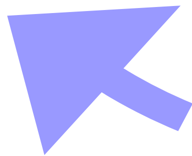
Step 4
Estimating impact

- Epidemiometric model
- Estimate the impact (reduction in mortality) of overcoming the bottlenecks based on local causes of NNMR, U5MR and MMR.
- Sources include *MDG 1 based on Emory, MDG 4 based on Bellagio, MDG 5 based on WHO/WB Cochran; BMJ, and MDG 6 RBM, UNAIDS.*



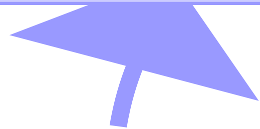
Step 4
Estimating marginal cost

- Estimate marginal costs to overcome the bottlenecks and achieve new performance frontiers.
- Region/country specific inputs and cost structures

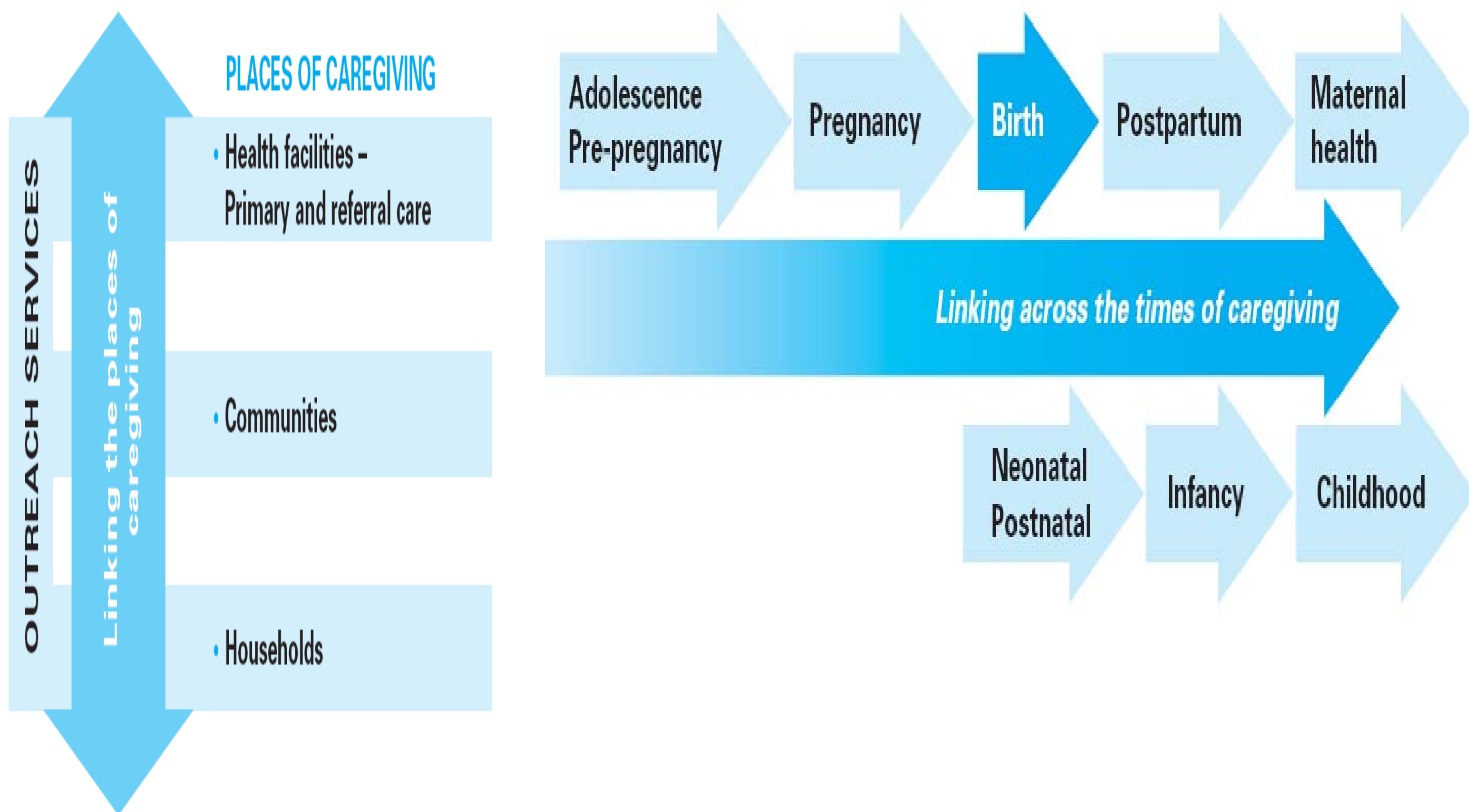


Step 5
Budgeting and fiscal space

- Translate marginal cost into yearly additional budget figures
- Link budget figures to national sector plans, MTEF, PRSP and other programs
- Facilitate analysis on financing sources
- Evaluate additional funding requirement against the fiscal space for health



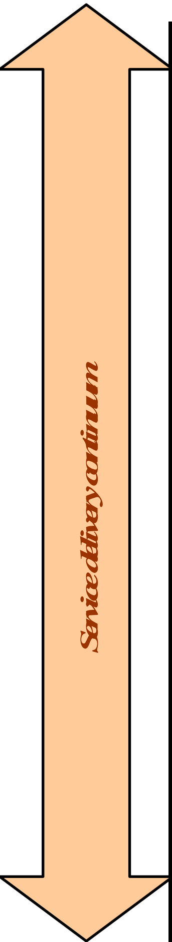
A Continuum of Care in Time and Place



_of_care/en/index.htm), accessed 30 September 2007

Priority interventions for MDG4 and their potential impact on neonatal and under-five mortality, grouped in illustrative service delivery modes

Interventions which contribute to MDG 5 | Interventions which contribute to MDG 6
Interventions which contribute to MDG 1 | Interventions which contribute to MDG 7

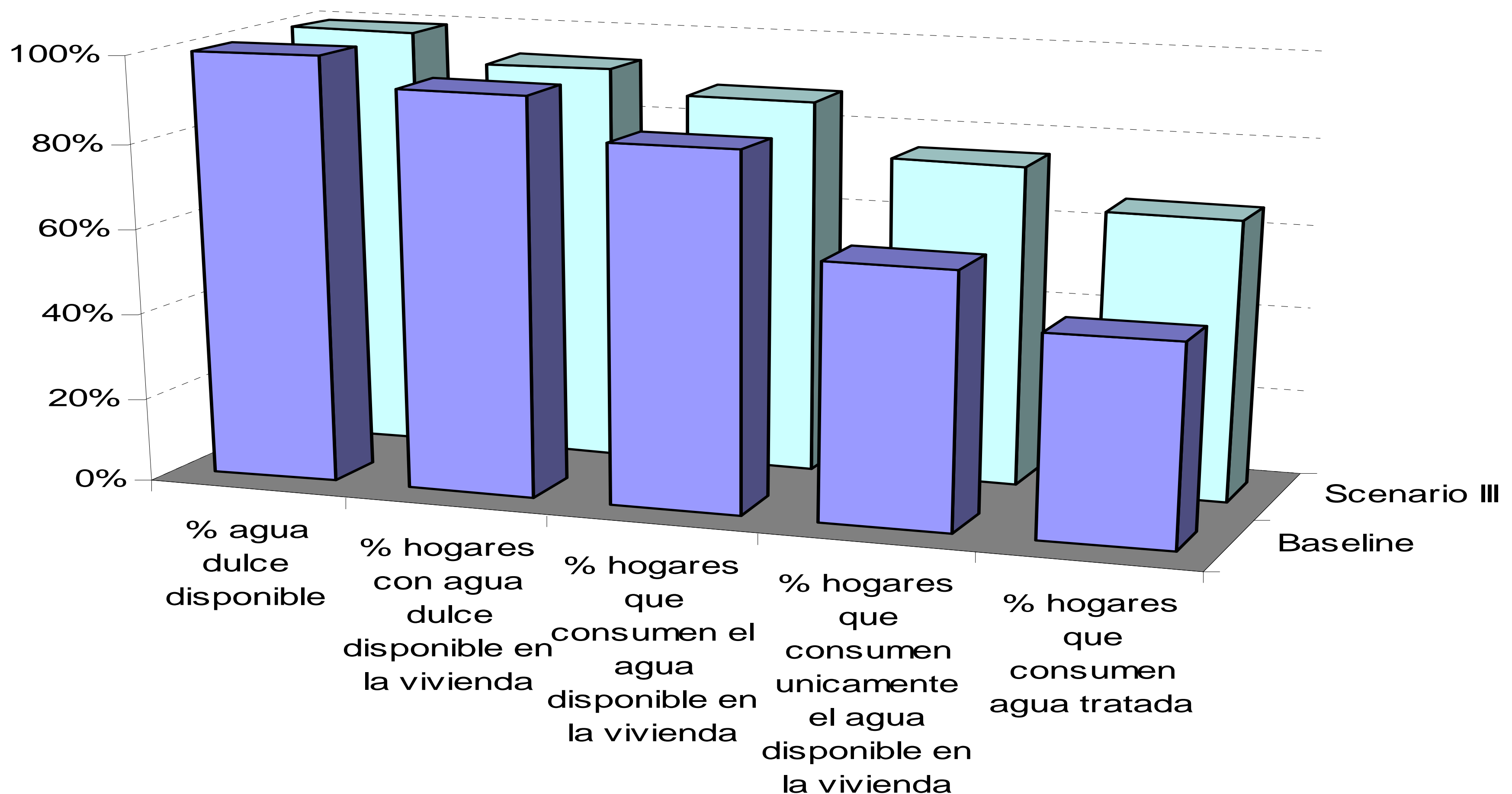


Service Delivery Modes		Pre-conceptual, Antenatal and Delivery Care	Neonatal and postnatal Care	Potential NNMR impact *	Child (post neonatal) Care	Potential U5MR impact
Preventive	Schedulable outreach services	Antenatal Care: -Tetanus immunization -Intermittent presumptive malaria treatment -Screening & management of: ▫ HIV ▫ Syphilis ▫ Micronutrients ▫ Iodine ▫ Iron ▫ Calcium	Vitamin A supplements Post-partum	8% (6-9%)	Childhood Immunization, especially measles and HIB Vitamin A supplements Zinc supplements	12%
Promotional	Family/Community Care	Clean Delivery	Clean cord care Thermal care Early breastfeeding Extra care of low birth weight infants	24% (15-32%)	Insecticide Treated Bednets Exclusive/continued breast feeding Complementary Feeding Hygiene and Water/Sanitation	35%
Curative			Early diagnosis & management of pneumonia in newborns		Oral rehydration/zinc Case management of: -Malaria -Diarrhoea -Pneumonia -HIV/AIDS	28%
			Subtotal impact	28% (18-37%)	Subtotal impact	50%
	Clinical Care: Primary	Skilled maternal and immediate Neonatal care		37% (23-50%)		14%
	Clinical Care: Referral	Emergency Obstetrical Care	Emergency Neonatal Care			
			Total Impact	48% (31-61%)	Total Impact	60%

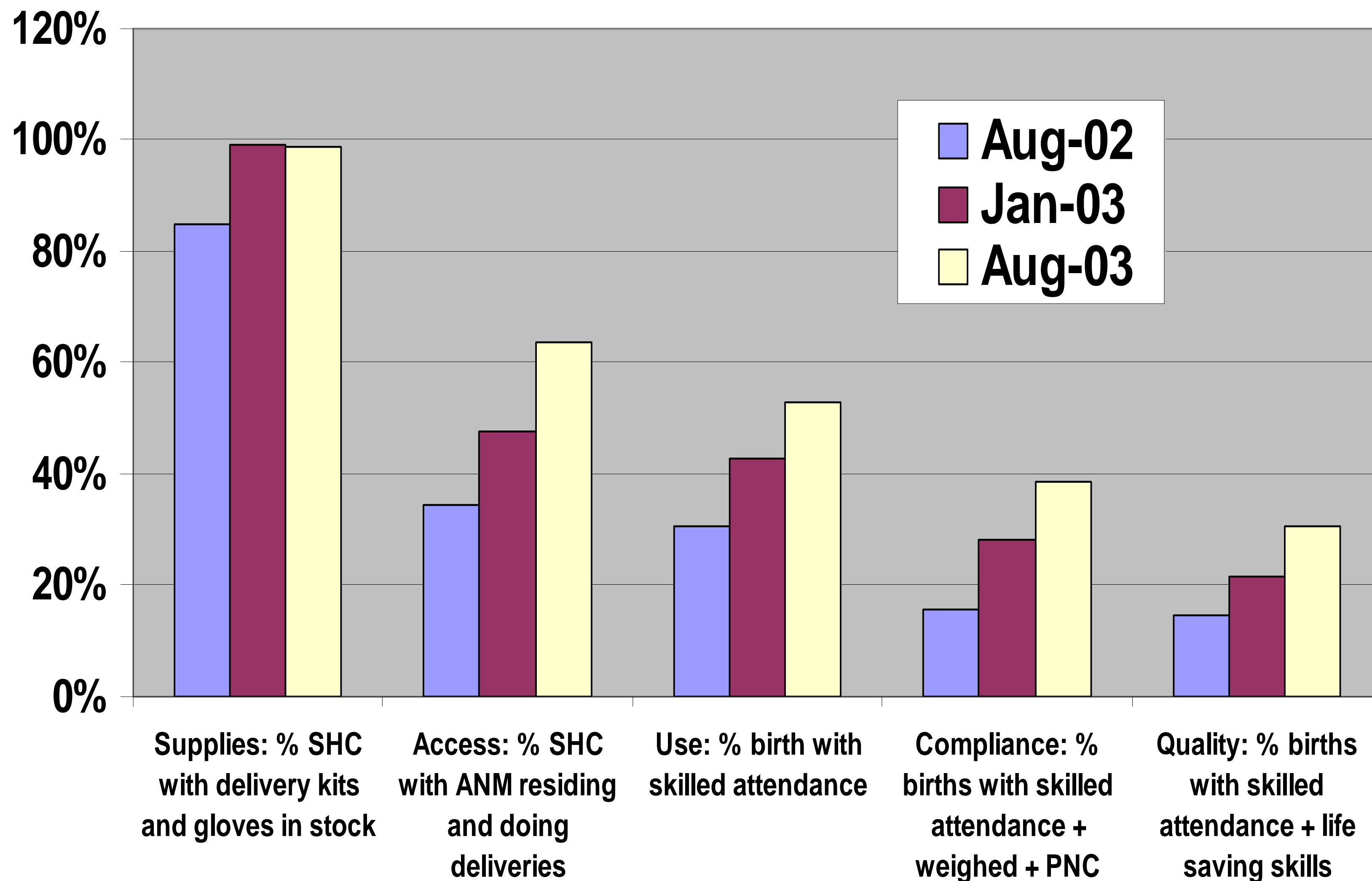
* neonatal mortality rate

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY
unicef

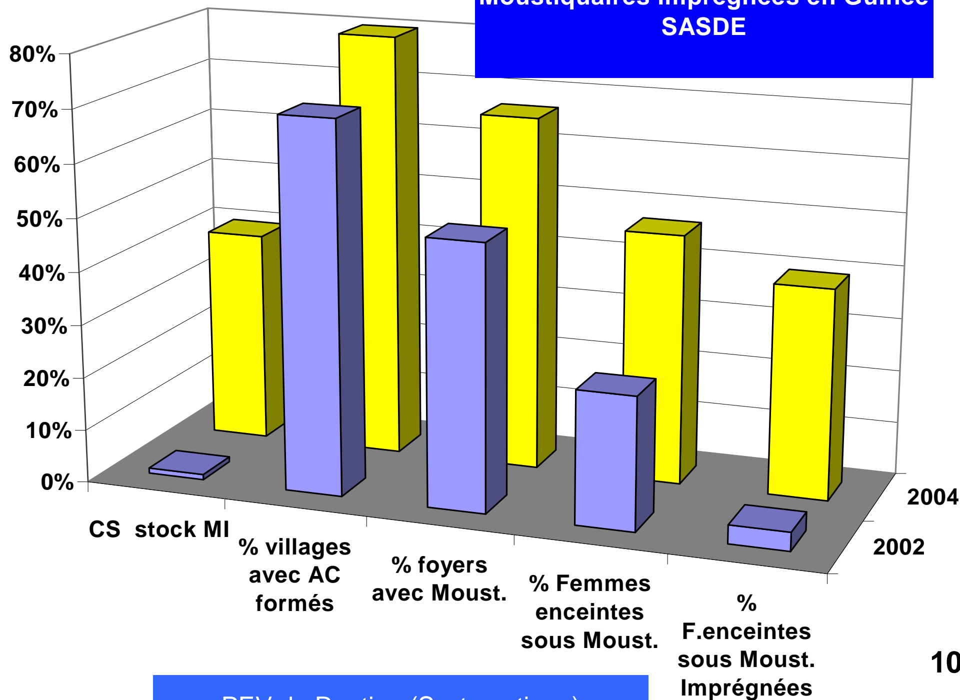
Bottlenecks in use of Safe Drinking Water in Honduras

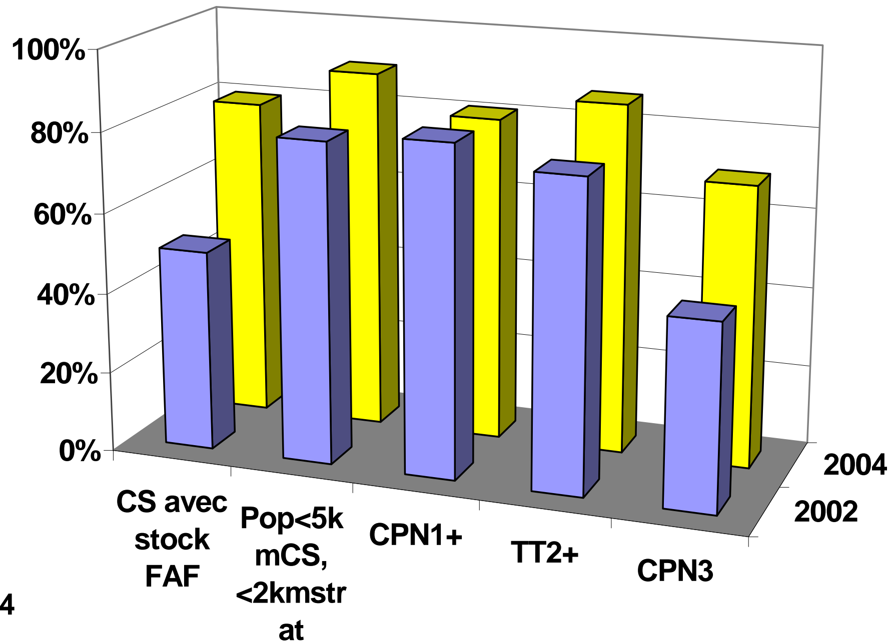


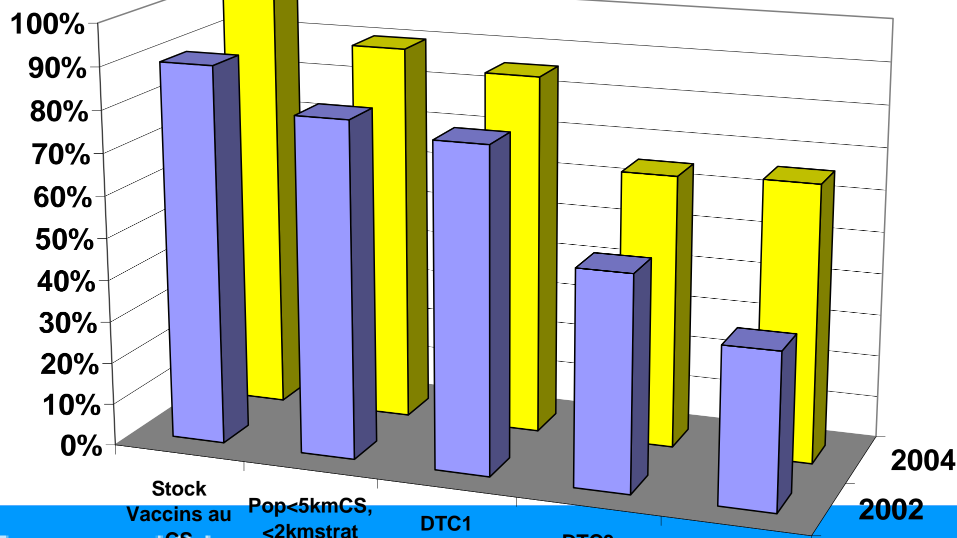
Evolution of skilled attendance and postnatal care in selected poor rural districts in Madyah Pradesh, India



Addressing Bottlenecks in ITN's, EPI and ANC in Guinea



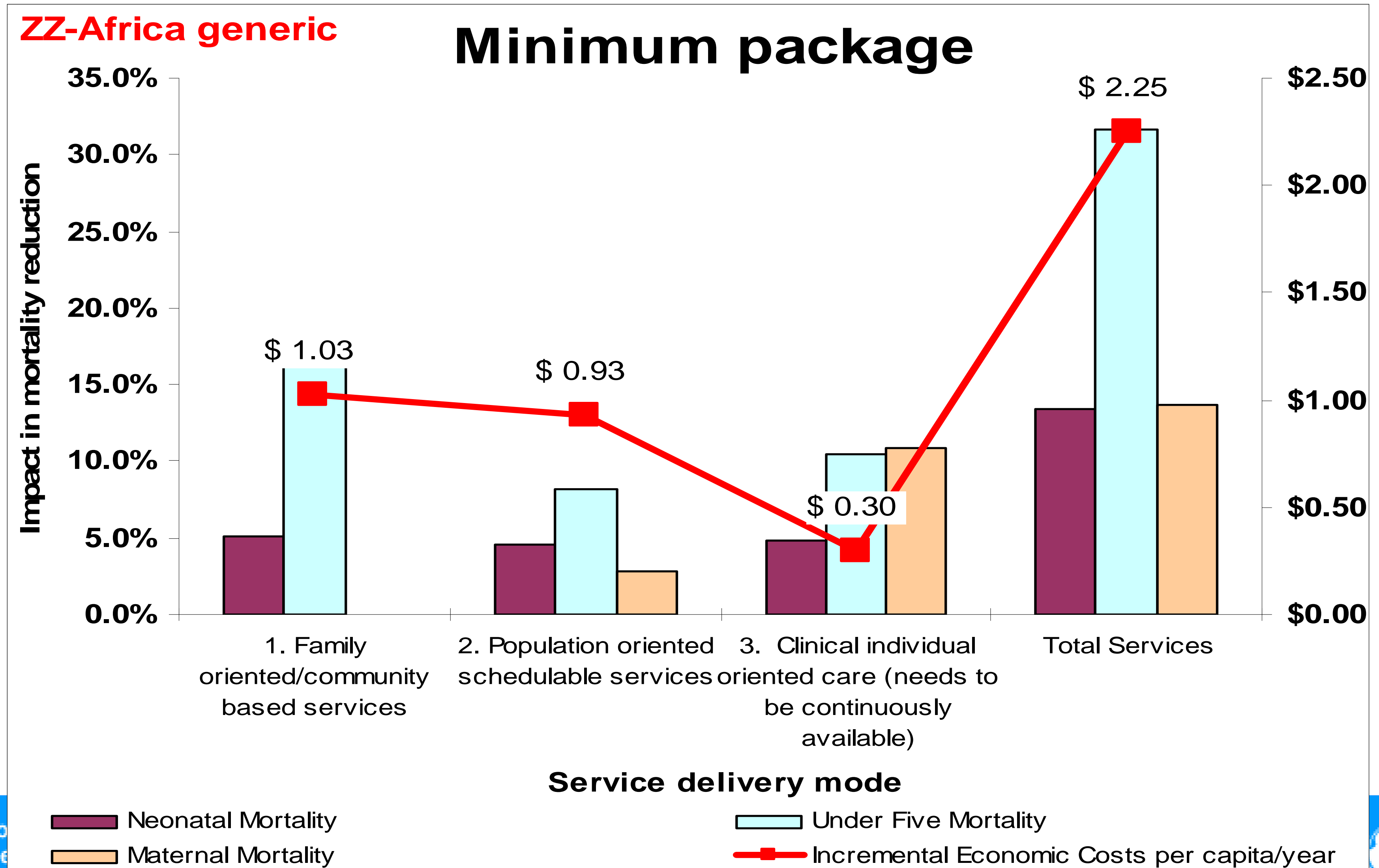




Ensuring increased, predictable and equitable financing mechanisms

- development of "compacts" between governments and development partners. A 'compact' commits development partners to providing:
  - sustained, predictable funding and more harmonized
  - aligned support
  - to robust results orientated national plans and strategies,
  - that also tackle health system constraints;
- results-based financing initiatives to reward performance (contracting in and out)
- developing innovative financing strategies such as conditional cash transfers, equity funds

Full Minimum Package at scale: 30% U5MR, 15% MMR, NNMR reduction for $ 800 per life saved



Fo
He
ADVANCE HUMANITY

Maximum Package at scale: 60% U5MR, MMR, 50% NNMR reduction for $ 2500 per life saved

ZZ-Africa generic

Maximum package

Impact in mortality reduction

70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%

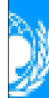
$14.00
$12.00
$10.00
$8.00
$6.00
$4.00
$2.00
$0.00

$ 2.76
$ 4.38
$ 5.39
$ 12.53

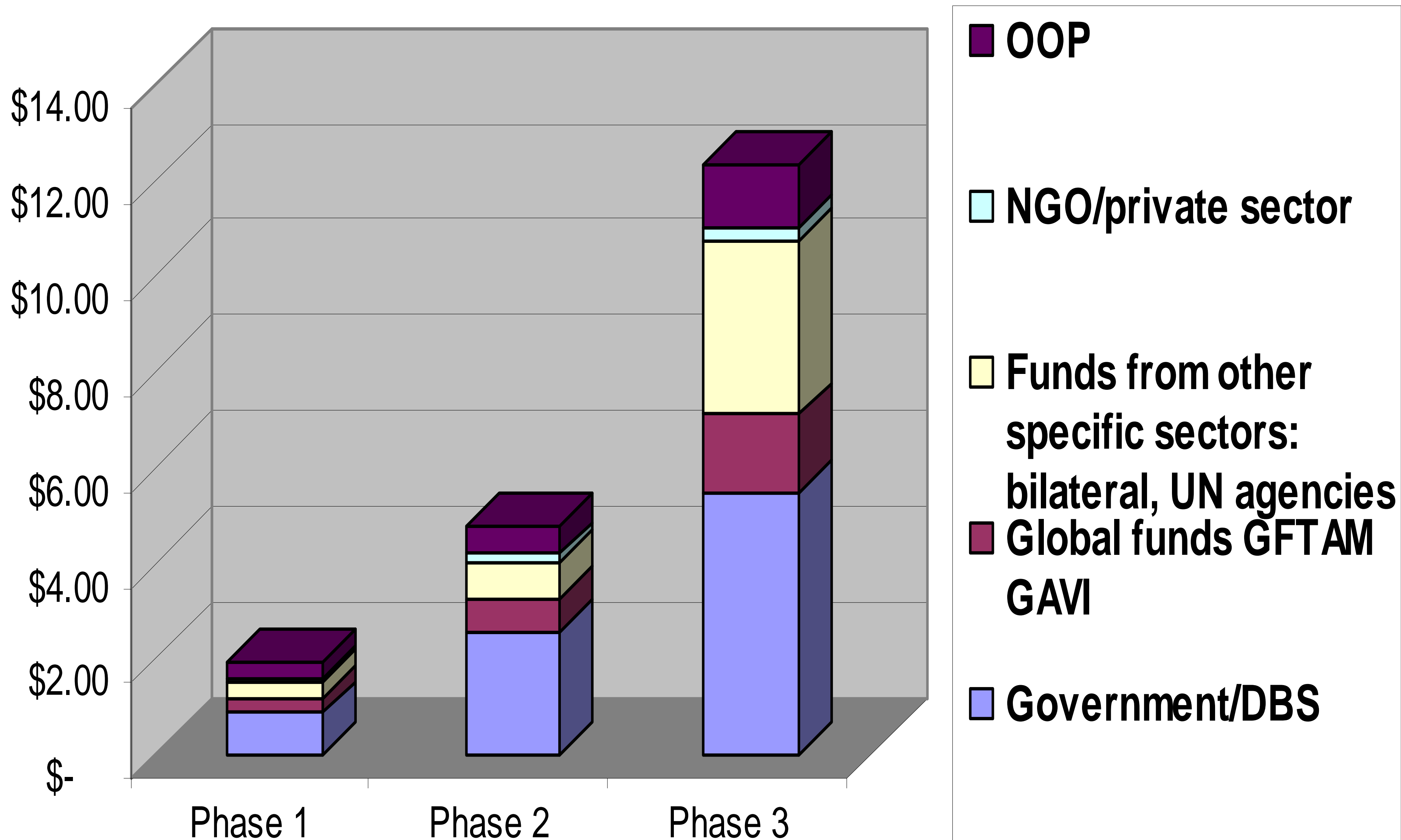
1. Family oriented/community based services
2. Population oriented schedulable services
3. Clinical individual oriented care (needs to be continuously available)
Total Services

Service delivery mode

Neonatal Mortality
Under Five Mortality
Maternal Mortality
Incremental Economic Costs per capita/year



Funding Sources for the Africa Strategic Framework for MDG 4,5



MOBILIZING POLITICAL COMMITMENT and SUSTAINED FUNDING
Recent Initiatives supported by International Health Partnership ++ (IHP++)

	International Health Partnership	Catalytic Initiative to Save a Million Lives	Deliver Now for Women and Children	Innovative Results-Based Financing	Providing for Health Initiative
Objective	•Accelerate scale-up of coverage and use of health services. •Improve delivery of MDG outcomes and universal access commitments. •First wave: Burundi, Cambodia, Ethiopia, Kenya, Mozambique, Nepal Zambia, •Being added Mali, Madagascar	Intensify efforts to achieve MDG 4&5 •Supporting and developing capacity of country-led health systems to deliver proven, affordable, integrated, high impact, affordable interventions	For MCH services: Strengthen civic activities' to increase demand •Hold political leaders accountable to invest $$ •Strengthen capacity of the media, •Enable scaling up of services to MCH mortality	Test out and evaluate RBF as mechanism to better achieve health outcomes. The aim is to get the greatest value for money spent	•Improve sustainable and equitable financing structures to enhance access to quality health services •Protect people from the adverse financial consequences of high out-of-pocket payment
Lead Partner	Health 8 agencies - WHO/ WB have coordinating roles	UNICEF	Partnership for Maternal, Newborn and Child Health	World Bank	France, Germany, and ILO
Lead Donor	United Kingdom	Canada US$100 million	Norway ??	Norway US$105 million	Supported by G8

Harmonization for Health in Africa (HHA)

WHO, WB, UNICEF,UNFPA, UNAIDS, AfDB, BMGF, GFATM and GAVI Harmonize

H8 Heads of Agency Meetings, International Health Partnership +, Harmonization for Health in Africa:

- Stimulate a global collective sense of urgency for reaching the health related MDG's
- Modify institutional ways of doing business (coordination and teamwork)
- Foster a more systematic and robust approach to knowledge management ad learning
- Recognition of the important opportunity presented by the renewed interest in health systems
- Recognition that the role of civil society and the private sector will be critical for success

Uniting for Child Survival
Pivotal actions at the macro-level

- **Create a supportive environment** for MNC survival by ensuring peace and security, equity and gender equality
- **Develop and strengthen the continuum of care across time and location** which is critical as the newborn period accounts for 40% of under 5 deaths
- **Scale-up integrated packages of essential services by strengthening health systems and community partnerships**
- ***Expand the data, research and evidence base***
- ***Leverage resources*** for mothers, newborn, and children: both from domestic sources (meeting Abuja target for African governments) as economies grow in Africa and particularly in Asia and from G8 donors and GHPs
- ***Make maternal, newborn and child survival a global imperative***. Donors, civil society, UN and the private sector must come together in a true Global Movement for Children.