

DEPARTMENT OF MATERNAL, NEWBORN,
CHILD AND ADOLESCENT HEALTH (MCA)

HIGHLIGHTS 2012–2013



Progress Report

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Foreword

This report presents highlights of the work accomplished by the WHO Department of Maternal, Newborn, Child and Adolescent Health (MCA) in 2012 and 2013. The scope and mandate of the work of the Department are broad. Through research, MCA generates new evidence to shape norms, standards and guidelines that serve to guide countries in adopting the most effective, evidence-based policies and strategies. It supports building capacity for moving towards universal access to high-quality, integrated health services, and supports the measurement of progress. Much of this work has been carried in collaboration between WHO headquarters, regional and country offices, with other departments of WHO and with partners.

The environment in which MCA works is dynamic, and progress is evident in all population groups. The global maternal mortality ratio fell by 47% between 1990 and 2010, and the under-five mortality rate decreased by 47% between 1990 and 2012. However, this progress is not sufficient, and achieving Millennium Development Goals (MDGs) 4 and 5 is still not ensured. In 2012, 6.6 million children died before their fifth birthday. Of these, nearly three million were newborns in their first month of life. 287 000 women died due to complications of pregnancy and childbirth, and the annual 2.6 million stillbirths remain silent tragedies. The health of adolescents has attracted increased attention. First, there are many of them – often more than 20% of the population, with the proportion highest in low and middle-income countries. Second, there is a growing recognition that the health problems and health-related behaviours that arise during adolescence have important implications for adult health, and for public health in general.

Multiple global efforts are under way to accelerate progress towards reducing maternal and child mortality and improving survival. The UN Secretary-General's Global Strategy for Women's and Children's Health, launched in 2010, is an unprecedented endeavour to save the lives of 16 million women and children by 2015. More recently, a number of initiatives have been initiated with aims of accelerating progress towards MDGs 4 and 5, and of ending preventable maternal and child mortality within one generation. The Child Survival Call to Action: A Promise Renewed sets out targets for reducing child mortality to 20 child deaths or less per 1000 live births by 2035. In support of this target, the integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea provides directions for ending preventable child deaths due to these two diseases. Similarly, "Every Newborn: an action plan to end preventable deaths" is in development to increase attention to this age group. Finally, the Family Planning Summit in 2012 set an ambitious goal to provide an additional 120 million women, in the world's poorest countries, with access to voluntary family planning by 2020.

While acknowledging the importance of these global initiatives as drivers for sustained action and commitment to improving maternal and child health, we are convinced that the most critical factor remains the extent to which they lead to action in countries. This is the mainstay of the work of the WHO Department of Maternal, Newborn, Child and Adolescent Health.

Preventing maternal deaths

HIGHLIGHTS OF 2012–2013

- WHO leadership on maternal death surveillance and response (MDSR)
- Two pivotal documents updated: PCPNC, and the Counselling Handbook
- Intensified attention to midwifery services and quality of care
- Promotion of innovative ways to increase and measure the quality of perinatal care in health facilities
- Mapping training resource packages for community health workers

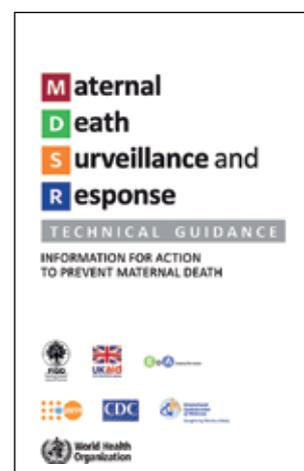
WHO leadership on maternal death surveillance and response (MDSR):

Carefully targeted interventions are the most effective in improving the quality of care provided, and ensuring maternal survival. Identifying these targeted interventions requires accurate information on maternal deaths: who died, when, where and why. Maternal death surveillance and response provides this information through the identification and timely notification of maternal deaths, followed by a review and analysis of the particular circumstances. MDSR also underpins better information on the magnitude of maternal mortality, better civil registration and vital statistics, and information on the quality of maternal and perinatal care.

MCA leads the international working group on MDSR, which includes partner agencies, academic and research institutions, professional organizations and advocacy groups. Starting with the first regional workshop on MDSR in the United Republic of Tanzania, the working group has introduced the concept of MDSR through regional and national workshops covering all 75 high-burden countries that account for 95% of maternal and child deaths.

A guidance document was published to assist countries in the transition from implementing simple maternal death reviews to implementing MDSR. WHO and partners have conducted capacity building activities on the use of MDSR, including two workshops (in London and Addis Ababa) for 40 experts from all WHO regions. WHO also ensured the translation of relevant materials into French.

Two pivotal documents updated: 1) *Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice (PCPNC)*; and 2) *Counselling for maternal and newborn health care: a handbook for building skills* (“Counselling Handbook”): The revised documents present a full range of norms and standards that enable health workers at first-level health facilities to provide high-quality, integrated care during pregnancy, childbirth and the post-natal period. Revisions were based on new guidelines concerning pre-eclampsia, eclampsia and postpartum haemorrhage; postnatal care for the mother and baby;



newborn resuscitation; prevention of mother-to-child transmission of HIV; infant feeding in the context of HIV; malaria during pregnancy; tobacco use and second-hand smoke exposure during pregnancy; post-partum depression; post-partum family planning; and post-abortion care.

Intensified attention to midwifery services and improving quality of care: After setting its own priorities in the area of midwifery services, with a focus on improving and sustaining the quality of care, MCA proceeded to champion midwifery at international events. At the Second Global Midwifery Symposium WHO hosted a panel discussion on quality of care, and at the Women Deliver Conference WHO co-led a process with the International Confederation of Midwives (ICM) to listen to the voices of midwives on the reality of the professional, economic and socio-cultural barriers faced by female health workers who provide 24-hour maternity care. A formal plan of action for the period 2014-2017 has been prepared with the ICM, focusing on improving quality of care, on strengthening education and research, and on revising ICM materials to ensure their compatibility with WHO recommendations.

The second report on *State of the World's Midwifery* is under development, for publication in 2014. For the first time, WHO is co-chairing the steering committee with UNFPA and ICM. All WHO regions are engaged in data collection and analysis, and the process is enhancing country-level alignment between WHO, UNFPA and the ICM midwifery associations.

A technical consultation on midwifery care resulted in a draft list of benchmarks concerning the number of midwifery providers needed, with which skills, where and when; it also



WHO

discussed education and regulation. The consultation formed the basis for agreement on the next steps to update benchmarks for density of midwifery personnel and to develop guidance on issues related to accessibility, acceptability, affordability and quality of maternal and newborn care.

Promotion of innovative ways to increase and measure the quality of care provided by skilled attendants: MCA is working with the Nepal Public Health Foundation on an implementation research project on overcoming barriers to scaling up utilization of skilled birth attendants in three geographic areas in western Nepal. After identifying barriers through surveys, focus group discussions and interviews with key informants, the research team is studying the effect of a package of interventions on improving utilization of skilled care by a) ensuring family support for pregnant women to reach care; b) using mothers' groups to make funds available for birth in a facility; c) making transportation available to reach the facility for birth or for complications; d) strengthening a woman-friendly environment in the facility; and e) strengthening security measures to enable skilled attendants to provide care for 24 hours a day, seven days a week.

In efforts to increase coverage rates of births using skilled attendants, many countries have been encouraging childbirth in health facilities. While the number of births in facilities has been rising rapidly, concerns remain about the quality of care provided. MCA and partners are working to develop a tool to assess the quality of this care, to develop indicators to monitor it, and to revise and update modules in the Service Availability Readiness Assessment (SARA) tool. A technical meeting convened by MCA in December 2013 resulted in a list of a core set of 19 relevant indicators.

Leading the H4+ work to map training packages for community health workers: There is increased country demand to ensure universal coverage of essential interventions by training community health workers (CHWs). In preparation for providing support, the H4+ partnership of multilateral agencies working in health mapped, under MCA leadership, existing training materials for CHWs in various components of sexual, reproductive, maternal, newborn and child health. This exercise aimed to bring to light gaps and opportunities for harmonizing approaches to developing CHW capacity. Thirty-one relevant training packages were identified; these were classified by health themes and analysed according to agreed parameters. A subsequent technical consultation was organized by MCA and UNFPA to agree on ways forward, including broad dissemination of the mapping. An article has been accepted for publication in early 2014 and a H4+ position paper is under discussion.

Preventing newborn deaths

HIGHLIGHTS OF 2012–13

- Leading the consultation process to develop the Every Newborn Action Plan
- Estimating causes of death
- Defining priorities for research on newborn health for 2013-2025
- Conclusions of MCA-supported research:
 - Home visits for newborns save lives
 - Treatment of possible serious bacterial infections in newborns is feasible on an outpatient basis
 - New evidence is available on the effect of vitamin A supplementation on infant survival

Leading the consultation process to develop the Every Newborn Action Plan: The increasing contribution of newborn deaths to under-five mortality has seized the attention of the global community. In response to concerns expressed by the World Health Assembly in recent years, an experienced group of stakeholders joined with countries and global partners to develop Every Newborn: an action plan to end preventable deaths (ENAP). This document will help countries identify actions for improving newborn survival, health and development, and will serve as a road map for change. The action plan recognizes the intricate link between the health of the mother and the newborn, and it proposes actions that effectively have the triple return of reducing newborn deaths, intra-partum stillbirths and maternal mortality.

WHO and UNICEF co-led the consultation process that was central to the development of the draft action plan. Consultations were launched at the Global Newborn Health Conference in South Africa in April 2013, followed by two intercountry meetings in Nepal and Senegal. Face-to-face consultations have since taken place in multiple countries and at global events. MCA developed a tool to identify bottlenecks to scaling up effective interventions to end preventable neonatal deaths. Results from its use in 20 countries informed the development of the draft plan.

Estimating causes of death: High quality, current data on the causes of newborn and child deaths are needed to ensure sound planning and priority-setting for the health interventions that will prevent these deaths. In spite of international efforts, most of the countries where more than 95% of under-five deaths occur still lack complete and accurate civil registration of deaths and their causes.

To fill this information gap, MCA, together with the Child Health Epidemiology Reference Group (CHERG), has developed estimates of cause-specific newborn and child deaths by utilizing information from mortality surveillance, from studies in small populations, and

from special surveys. The estimates are provided for national, regional and global levels on a regular basis. In addition, trends are analysed to facilitate monitoring changes over time. The most recent estimates, shown in Figures 1 and 2, were released in 2013.

FIGURE 1 Causes of neonatal and child mortality

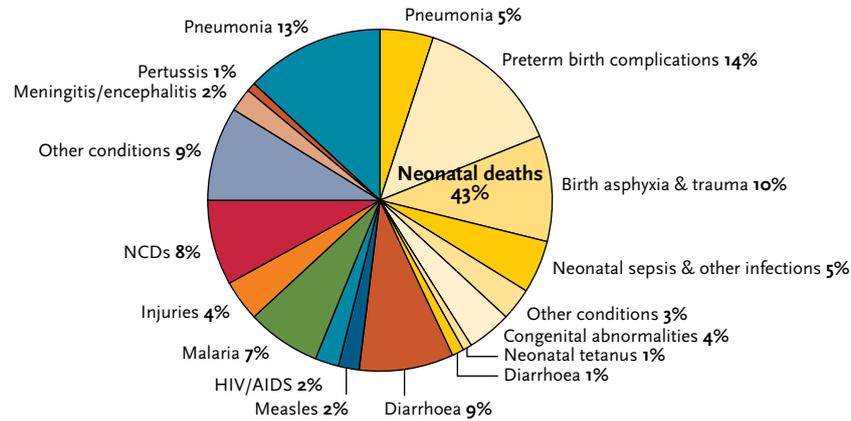
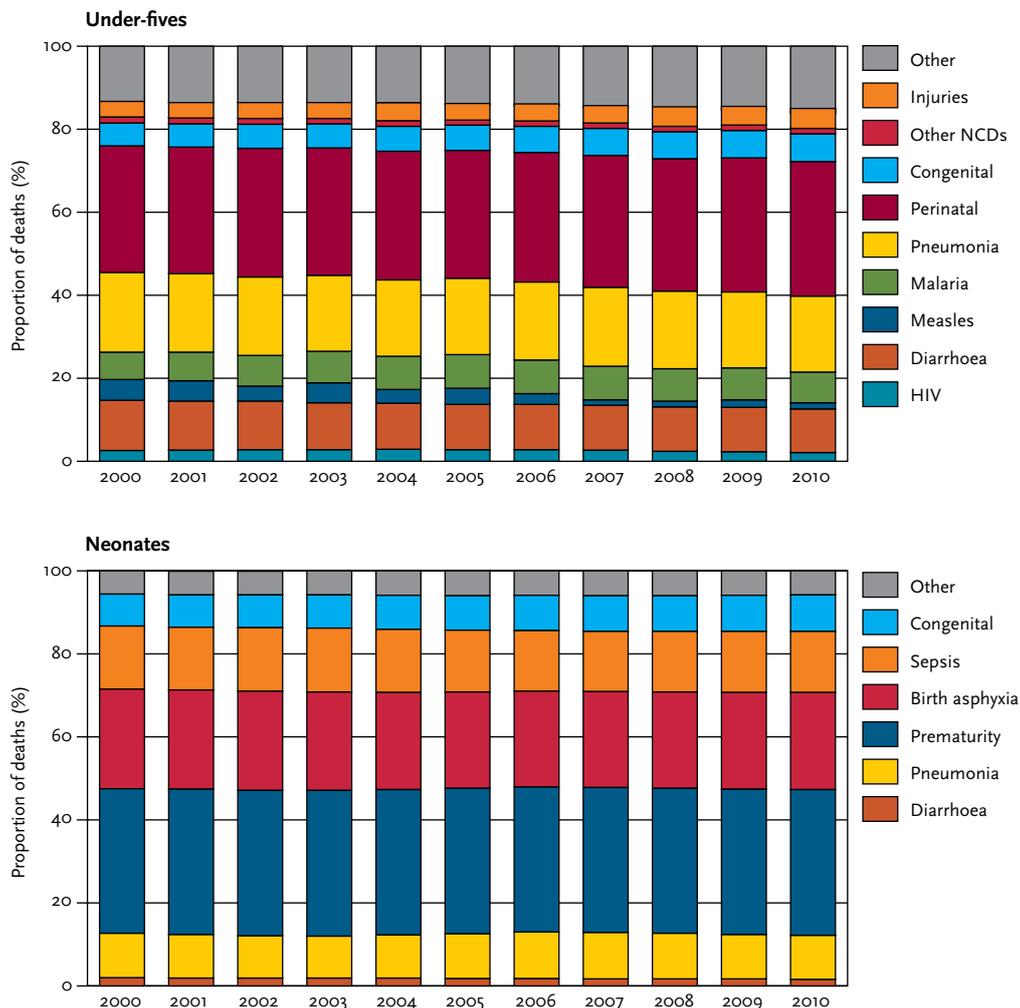


FIGURE 2 Trends in under-five mortality and neonatal mortality



Defining priorities for research on newborn health for 2013–2025: MCA in collaboration with Saving Newborn Lives/Save the Children conducted a global exercise to set research priorities for newborn health for the period 2013–2025. A set of 200 of the most productive researchers and 400 programme experts were approached. A total of 132 researchers and programme experts submitted potential research questions online, and the resulting list of 205 questions was sent for scoring to the experts originally contacted. The refined research questions were scored by 91 experts against five pre-defined criteria (answerability, efficacy, deliverability, impact and equity). The exercise resulted in research priorities in three domains: delivery (delivery of known interventions exploring how to take them to scale), development (improve the delivery of existing interventions), and discovery (new and novel interventions). The top ten questions concerned finding approaches to scaling up simplified means of newborn resuscitation at lower levels of the health system, identifying and managing newborn infection at the community level, addressing barriers to scaling up exclusive breastfeeding and facility-based Kangaroo mother care (KMC), evaluating the use of chlorhexidine in umbilical cord care for neonates born in health facilities, and developing strategies to improve the quality of facility-based care provided during labour and childbirth.

The resulting list of questions will assist both donors and researchers in setting priorities to address the key gaps in knowledge that could make the most difference in saving newborn lives and preventing stillbirths. MCA will work with partners to generate interest among key national stakeholders, governments, NGOs, and research institutes, and to encourage funders to support these priorities.

Conclusions of MCA-supported research in 2012–2013:

- **Home visits for newborns save lives:** Two large-scale community randomized trials that evaluated the implementation of home visits for newborn care were completed during the biennium. The first study evaluated Integrated Management of Childhood and Newborn Illness (IMNCI) in two districts in India. The intervention included home visits for postnatal care. The study showed a 15% reduction in infant mortality in all births; this increased to a 20% mortality reduction among home births. In addition, the study demonstrated substantial reductions in neonatal and infant morbidity, and improvements in optimal newborn care practices such as the early initiation of breastfeeding, exclusive breastfeeding, and care-seeking for illness. The second study, conducted in seven rural districts in central Ghana, evaluated home visits during the pregnancy and postnatal periods. This was the first large study in Africa that reported an impact of such an intervention on newborn mortality and on maternal and newborn care practices. The intervention reduced neonatal mortality by 8%, and increased coverage of key essential newborn care behaviours including care-seeking for illness, early initiation of breastfeeding, skin-to-skin contact and exclusive breastfeeding.

Results of a new meta-analysis including the two studies described above showed a 12% reduction in neonatal mortality in four trials undertaken in programme settings, compared with a 45% reduction in mortality in four proof-of-principle studies. The findings from the new studies and the meta-analysis, while confirming the benefits of home visits for survival and newborn care practices, show that benefits are smaller when the intervention is implemented in programme settings compared with efficacy settings. In 2013, WHO guidelines on postnatal care were updated, and home visits for postnatal care are now part of the delivery strategy for key maternal and newborn health interventions.

- **Treatment of possible serious bacterial infections in newborns is feasible on an outpatient basis:** About 700 000 neonates who die every year due to severe infections could be saved with appropriate antibiotic treatment. WHO guidelines recommend hospital admission and treatment with a combination of ampicillin (or penicillin) and gentamicin injections. However, experience from research and implementation shows that most young infants with clinical signs of possible severe bacterial infection in resource-poor settings are not taken to hospitals. Studies in Bangladesh and India reported substantial benefits of treating these children at home under experimentally controlled circumstances. A review of programmatic experience from all countries in South Asia and Sub-Saharan Africa showed that none of the countries had implemented a home-based approach where community health workers provide antibiotic injections.

To find an alternative strategy that would be more acceptable to policy makers, the Department coordinated a set of large research studies in Sub-Saharan Africa (Democratic Republic of the Congo (DRC), Kenya and Nigeria), and supported similar research in South Asia (Bangladesh and Pakistan). In these studies, young infants with signs of possible severe bacterial infection were identified either by community health workers during home visits, or by the parents. These infants were then assessed by a study physician or nurse, using young infant IMCI guidelines. If a young infant was confirmed to have signs of a possible serious bacterial infection, but the parents refused to take him or her to a hospital, treatment was provided by trained first-level health workers at facilities near the home, or at home. In an effort to identify the simplest effective treatment, the study randomly assigned infants to one of four groups with decreasing numbers of injections. Treatment was provided for seven days and the infants were followed up for 14 days after enrolment. The studies showed that about 60% of young infants with signs of possible serious bacterial infection were not taken to the hospital. More than 90% of those who were not taken to hospital were



successfully treated on an outpatient basis, using any of the four regimens. Fewer than 2% died in the two-week follow-up period.

On the basis of this evidence, WHO is reviewing the guidelines on treatment of possible serious bacterial infections in situations where referral is not possible.

- **New evidence is available on the effect of vitamin A supplementation on infant survival:** Previous evidence on the effectiveness of Vitamin A supplementation on newborn health has been inconsistent. While supplementation is recommended for children between 6–59 months of age based on evidence that it improves child survival, it has not been shown conclusively that this improvement applies to younger infants. A small number of studies had found that vitamin A supplementation during the first two to three days of life improved newborn survival. Two Cochrane reviews summarizing the same studies reached different conclusions. Policy implications were unclear, with some groups advocating for this intervention and others arguing against it.

WHO was requested to resolve this controversy by coordinating extensive research studies in diverse populations. In response, MCA coordinated three large randomized controlled trials in Ghana, India and the United Republic of Tanzania. Newborns were identified in health facilities or at home within 72 hours of birth and provided either a single dose of 50 000 i.u. vitamin A, or a placebo. Mortality and hospital admission were measured until the infant reached the age of 12 months. The primary outcome was mortality up to the age of 6 months. In order to obtain a definitive answer to the research question, these studies enrolled close to 100 000 infants.

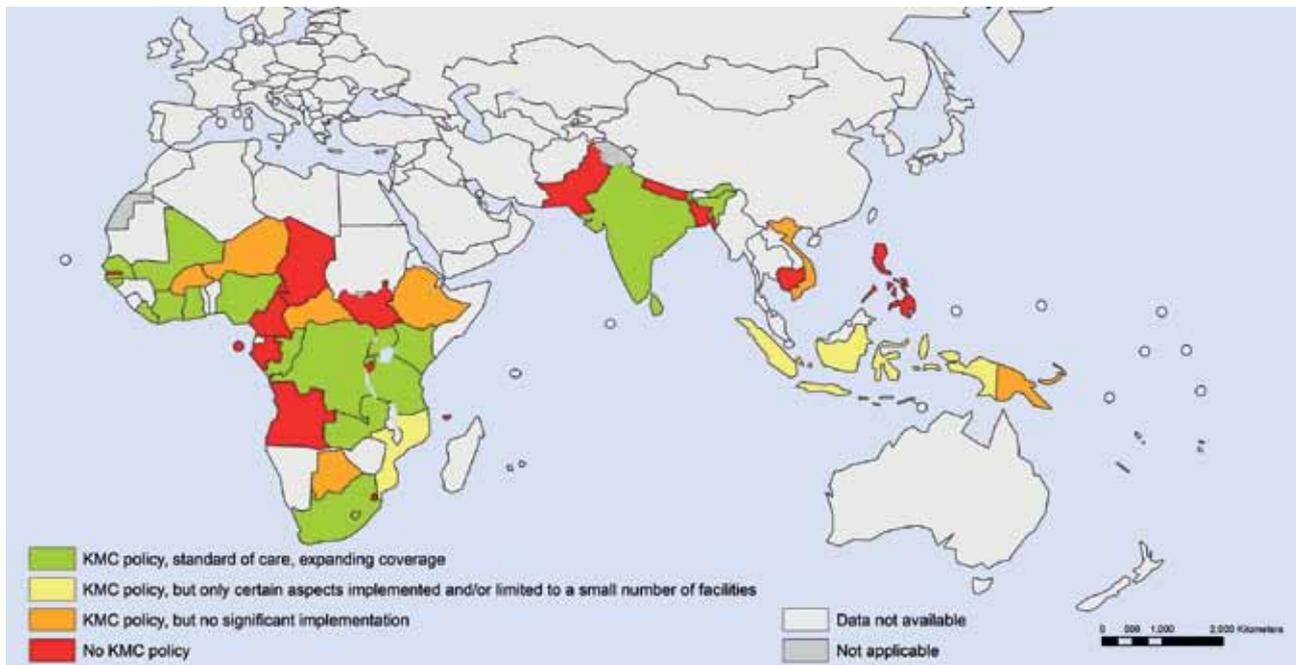
The study in India showed a 10% reduction in mortality up to the age of 6 months, but this benefit was no longer apparent by 12 months of age. There was no benefit of the intervention on survival in either Ghana or the United Republic of Tanzania. A meta-analysis of all trials, including these three indicates that the beneficial effect is related to underlying vitamin A deficiency in populations. Neonatal vitamin A supplementation reduces mortality in settings where pregnant women or mothers are vitamin A deficient, and has no effect or a potentially harmful effect in settings where mothers are replete. A pooled analysis of the data will be conducted and a meeting to interpret the results will be held in April 2014, followed by the formulation of updated WHO guidelines.

New guidance to improving outcomes of preterm birth: Prematurity is now the second most important cause of under-five mortality after pneumonia, yet interventions that would improve outcomes of preterm birth are not widely implemented. Improved management of pregnant women at risk of preterm delivery (including the use of antenatal corticosteroids), improved management of childbirth and better handling of the premature infant bring a triple return on investment, saving mothers, newborns and unborn children. MCA has compiled evidence and initiated the process for issuing new guidance.

Monitoring implementation of Kangaroo mother care to improve outcomes of preterm birth: Despite evidence of efficacy for and decades of experience with KMC, this intervention is not yet mainstream. All too often, implementation remains restricted to a limited number of committed centres, organizations or institutions. Recently, however, KMC has been recognized more widely as having significant potential to increase the survival of preterm infants, particularly in low-resource settings. MCA conducted a survey to document the state and quality of implementation of KMC in high-burden countries, and to identify barriers to and enabling factors for implementing KMC at scale. There were 93 responses from 42 countries (32 in Africa, 10 in Asia), from staff of UN agencies, clinicians and ministries of health. Twenty-seven of the 42 countries have a policy on KMC, but not all include the four key elements: early, continuous and prolonged skin-to-skin contact (23);

exclusive breastfeeding or breastmilk feeding (23); early discharge after hospital-initiated KMC (13); and adequate support and follow-up (18). The state of implementation in those countries from which responses were received is summarized in Figure 3.

FIGURE 3 Kangaroo mother care implementation survey results 2013



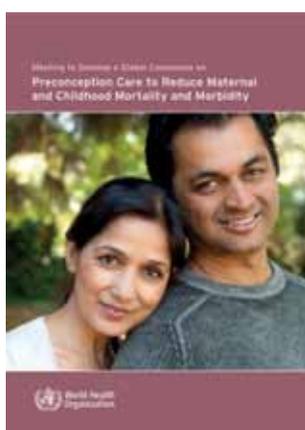
Improving skills for essential newborn care: MCA in collaboration with partners has developed an e-learning module for health workers on essential newborn care. The module is part of the larger project on computer-assisted learning, the Integrated Management of Pregnancy and Childbirth training tool (IMPACTt), and will be complemented by modules on antenatal care, childbirth and postnatal care. MCA is also working to ensure that education programmes for health workers in resource-limited settings are in line with technical WHO guidance.

Promoting innovative work for the mother–newborn pair

HIGHLIGHTS OF 2012–2013

- Community mobilization through women’s groups can improve maternal and newborn health
- Description of the positive effect of preconception care on maternal and child health
- Updated recommendations on postnatal care of the mother and newborn

Community mobilization through women’s groups can improve maternal and newborn health: Recently-completed research reveals that the implementation of community mobilization through facilitated participatory learning and action cycles with women’s groups can improve maternal and newborn health, particularly in rural settings with low access to health services. In 2013, a systematic review and meta-analysis showed a 37% reduction in maternal mortality and a 23% reduction in neonatal mortality. The WHO Guidelines Development Group concluded that the evidence about the beneficial effect of the intervention on newborn mortality was clearer than the evidence of its effect on other outcomes, including maternal health and care-seeking. WHO guidelines on women’s group interventions have been developed and are expected to be published in early 2014. Implementation of facilitated women’s groups requires close attention to quality; therefore it was recommended that this intervention be implemented with close monitoring and evaluation, and with prior adaptation to the local context.



Description of the positive effect of preconception care on maternal and child health: Preconception care is the provision of biomedical, behavioural and social interventions to women and couples before conception occurs. Many of these interventions address the same health issues, problem behaviours and risk factors that compromise maternal, newborn and child health. Moreover, by supporting women to make well-informed and well-considered decisions about their fertility and health, preconception care contributes to the social and economic development of families and communities. There are indications that creating awareness of the impact of men’s health and men’s behaviour on maternal and child health outcomes, and promoting male involvement, could lead to even further benefits.

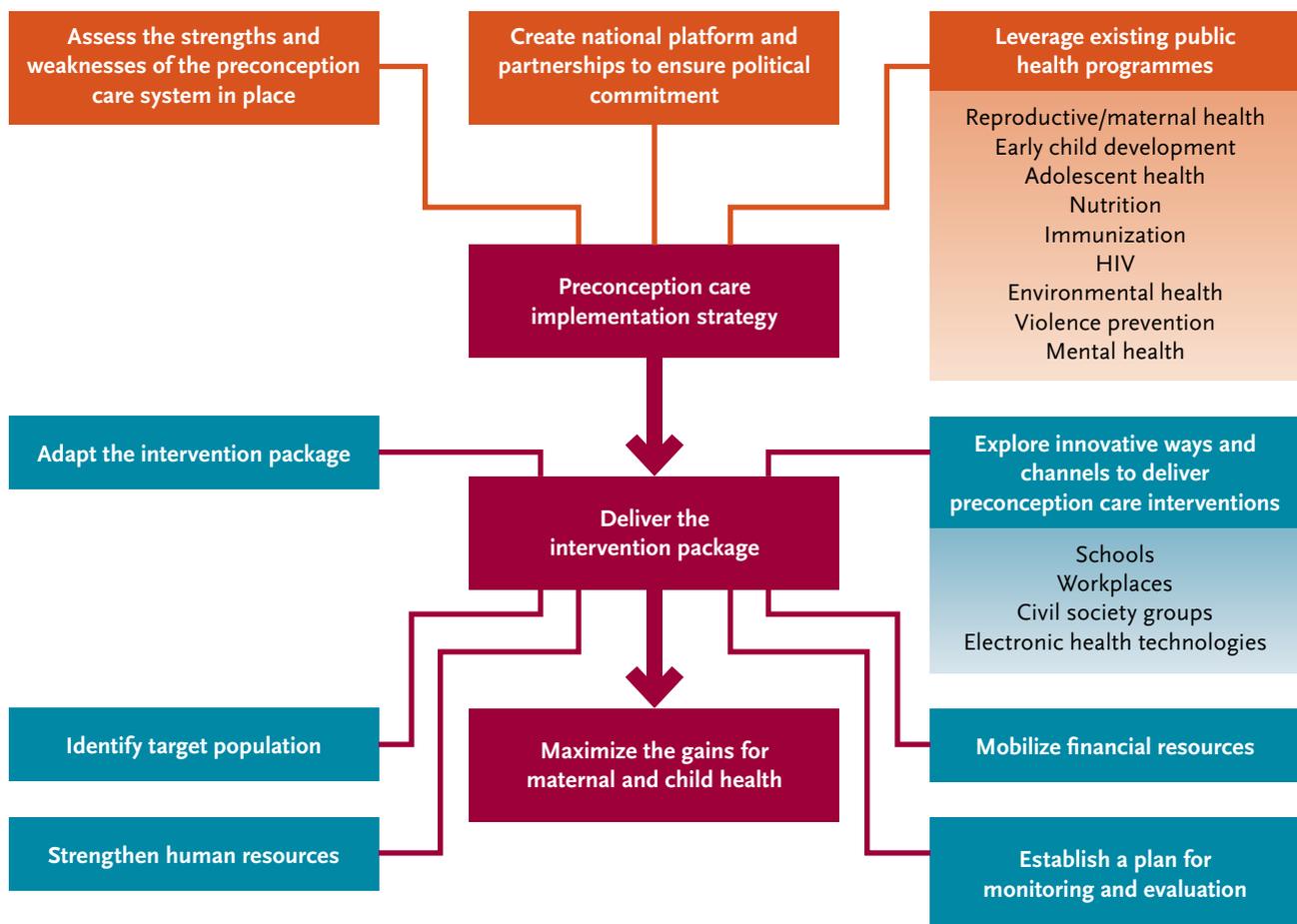
In 2012, MCA and a range of relevant WHO departments brought together researchers, practitioners and programme managers, plus UN agencies and other partners to achieve global consensus on the place of preconception care in overall strategies to improve maternal and child health. The meeting resulted in agreement to:

- build regional and national capacity to plan, implement and monitor preconception care interventions and services;
- stimulate and support country action;
- carry out demonstration projects in selected countries; and
- document and disseminate good practices for preconception care.

In 2013, WHO released a report showing that preconception care has a positive impact on maternal and child health (*Nurturing human capital along the life course: investing in early child development*). Targeted primarily at those responsible for developing national health policies, the report provides a foundation for implementing a package of defined promotive, preventive and curative interventions. In addition, WHO has proposed a strategy for country actions.

MCA has engaged with regional offices and international partners to facilitate opportunities for sharing country experiences and providing mutual support. In the South East Asia Region an expert consultation was held to discuss how to position preconception care in the context of the regional strategy to prevent maternal and childhood mortality and morbidity. Discussion is under way with partners and WHO offices in the European and Eastern Mediterranean Regions to organize regional meetings with Member States.

FIGURE 4 A strategy for country action to promote preconception care



Updated guidelines for newborn health:

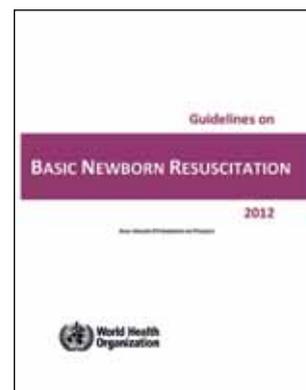
Postnatal care guidelines: The greatest proportion of maternal and infant deaths occur during the critical postnatal period, the first six weeks after birth. Nonetheless, this period has been the most neglected for the provision of high-quality care. In response, MCA led a review of available evidence and the subsequent revision of WHO guidelines.



In addition to updated technical content, the revised guidelines recommend the timing, number and place of postnatal contacts. The guidelines are mainly intended for health professionals who provide postnatal care to women and newborns, primarily in areas where resources are limited. The guidelines may also be useful to policy-makers and managers of maternal and child health programmes, health facilities, and teaching institutions. In addition, the information can be included in job aids and tools for both pre- and in-service training of health professionals.

The recommendations will be regularly updated as more evidence is gathered and analysed, with major reviews and updates foreseen at least every five years. The next update will be considered in 2018 under the oversight of the WHO Guidelines Review Committee.

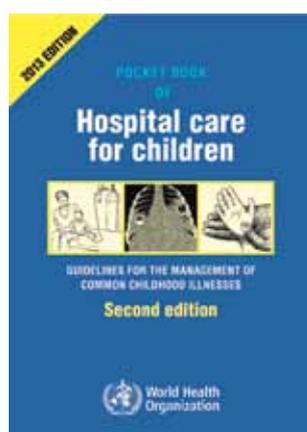
Guidelines on basic newborn resuscitation: Globally, about one quarter of all neonatal deaths are caused by birth asphyxia, defined as the failure to initiate and sustain breathing at birth. Effective resuscitation can prevent a large proportion of these deaths, and the need for up-to-date clinical guidelines suitable for settings with limited resources was universally recognized. MCA updated the decade-old document *Basic newborn resuscitation: a practical guide*. The updated guidelines will inform WHO training and reference materials, and will assist programme managers to develop or adapt relevant national or local guidelines, standards and training materials.



Preventing child deaths and promoting child development

HIGHLIGHTS OF 2012–2013

- Release of the Second edition of the *WHO Pocket book of hospital care for children*
- Coordination of the paediatric input to *Consolidated guidelines on HIV treatment and care: Recommendations for a public health approach*.
- Exploring the management of persistent diarrhoea in children
- Improving the quality of paediatric care
- Development of distance learning course materials on IMCI
- Publication of the WHO/UNICEF *Joint Statement on integrated community case management of childhood illness*
- Launch of the integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (GAPPD) and a special edition of *The Lancet*
- Handbook to plan community child health
- Increasing global attention to early child development and nutrition



Release of the Second edition of the *WHO Pocket book of hospital care for children*: The *WHO Pocket book of hospital care for children* aims to support countries in the development of their national paediatric guidelines for first-level referral hospitals. Originally available in 2005, the *Pocket book* was updated in 2013 and published as the Second Edition. The updated document was launched at the International Congress of Paediatrics in Melbourne, Australia. Over 15 000 copies were initially printed: 10 000 for free distribution to developing countries and 5 000 for sale through the WHO bookshop. To date over 126 000 copies have been either sold or distributed to developing countries. The *Pocket book* is being translated into French; translation into Russian and Spanish is planned for 2014.

The results of the systematic reviews used to inform the revisions were published separately as *Recommendations for management of common childhood conditions: Evidence for technical update of Pocket book recommendations*.

Coordination of paediatric input to *Consolidated guidelines on HIV treatment and care: Recommendations for a public health approach*: MCA coordinated the paediatric aspects of consolidated guidelines on antiretroviral (ARV) drugs, launched in 2013. These guidelines concern



the diagnosis of HIV infection, the care of people living with HIV, and the use of ARVs for treating and preventing HIV infection. The guidelines are structured along the continuum of HIV testing, care and treatment, and give clinical, service delivery and programmatic guidance relevant to adults, pregnant and breastfeeding women, adolescents, and children.

The consolidated guidelines recommend a broader eligibility for antiretroviral therapy (ART), defining the CD4 threshold for treatment initiation as 500 cells/mm³ or less for adults and adolescents, with priority given to individuals with severe or advanced HIV disease and those with CD4 count of 350 cells/mm³ or less. ART initiation is recommended irrespective of CD4 count for children younger than five years of age.

Exploring the management of persistent diarrhoea in children: An analysis of verbal autopsy data on diarrhoea-specific under-five mortality from seven countries showed that persistent diarrhoea, defined as diarrhoea lasting 14 days or more, is still a major contributor to infant and childhood mortality. The proportion of deaths due to diarrhoea varied considerably among the seven sites (demographic surveillance sites in Bangladesh, Ethiopia, Uganda and the United Republic of Tanzania, cohort studies in Ghana and India and national health surveys in Pakistan), from less than 3% to as high as 30%. Acute watery diarrhoea accounted for 32% to 85% of the deaths, while bloody diarrhoea accounted for 10% to 15%, and persistent diarrhoea for 10% to 61%. In Ethiopia, India, Pakistan and the United Republic of Tanzania persistent diarrhoea accounted for more than 30% of all diarrhoeal deaths. In most sites, severe malnutrition was present in over 40% of deaths due to persistent diarrhoea.

Although the use of ORS and zinc remains low in many countries, the majority of the persistent diarrhoea deaths in the sites studied did receive ORS or IV fluids. While the scale-up of ORS and zinc needs continuous support, further focus is needed on the treatment of persistent diarrhoea. In response, MCA is organizing an expert meeting to examine the existing guidelines and research gaps.

Improving the quality of paediatric care: MCA, in collaboration with two regional offices coordinates a multi-year initiative on improving the paediatric quality of care in four countries: Angola, Ethiopia, Kyrgyzstan and Tajikistan. The initiative, carried out in collaboration with the National Scientific Centre of Children's Health of the Russian Federation, and the Russian Academy of Medical Sciences aims to strengthen the capacity

The initiative on improving the quality of paediatric care counts among its achievements:

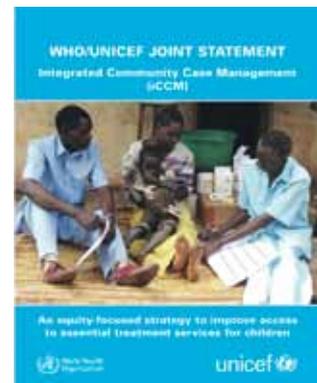
1. Development or updating of national paediatric care standards, clinical guidelines and clinical protocols or job aids for use in hospitals.
2. Capacity building to date of over 600 health workers in Ethiopia, Kyrgyzstan and Tajikistan using the *Pocket book* and the *WHO Emergency Triage Assessment and Treatment (ETAT)* guidelines as the standards.
3. Scaling up of quality improvement activities nationwide and establishing national mechanisms of quality care improvement in hospitals along the continuum of care.
4. Leveraging international and national partners including increased national resources to address quality of care in hospitals.

Experience gained is being used to develop a model for national scale-up of quality improvement activities for maternal, newborn and child health.

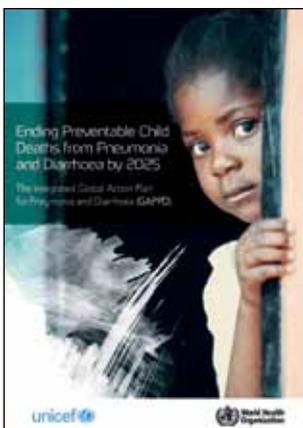
of national health systems to reduce case fatality from common childhood illnesses in first-level referral hospitals. It has been very successful in catalysing an increased focus on the quality of paediatric care in all four countries; this focus goes beyond the hospital level to cover the entire continuum of care. An assessment of 50 hospitals in the four countries led to national stakeholders' meetings to address gaps and to develop national action plans to improve paediatric quality of care.

Development of distance learning course materials on Integrated Management of Childhood Illness (IMCI): MCA field-tested paper-based distance learning materials in the African Region, starting in Ethiopia, then in South Africa and the United Republic of Tanzania, and most recently in Zimbabwe. The results of the field tests show that it is feasible, acceptable and cost-effective (approximately one-tenth of the cost of the standard IMCI course) to run a paper-based distance learning course on IMCI coupled with use of DVDs at home, regular mobile phone reminders, group learning exercises and a small number of face-to-face meetings with senior facilitators to ensure the acquisition of clinical skills. All countries involved have developed national materials and used them in selected areas. Follow-up visits to evaluate the performance of health professionals trained using this approach have shown equivalent results to those of the standard course.

Publication of the WHO/UNICEF Joint Statement on integrated community case management of childhood illness: This statement, subtitled *An equity-focused strategy to improve access to essential treatment services for children*, presents the latest evidence for integrated community case management of childhood illness, describes the necessary programme elements and support tools for effective implementation, and lays out actions that countries and partners can take to support the implementation of iCCM at scale. The statement was endorsed and supported by Save the Children and USAID; it is a powerful advocacy tool for partners and governments.



Launch of the integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (GAPPD), and a special edition of *The Lancet*: Inter-connected initiatives provide a platform to accelerate progress towards achieving the MDGs. One such initiative, under the umbrella of A Promise Renewed, is the integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (GAPPD). This initiative gives the global community an historic opportunity to end preventable child deaths by focusing on pneumonia and diarrhoea, which together account for 29% of all under-five deaths. The GAPPD provides guidance primarily to national governments and their partners, and secondarily to global organizations, donor agencies and other actors working on diarrhoea and pneumonia control.



The GAPPD was launched in April 2013 along with a four-paper series on childhood pneumonia and diarrhoea in *The Lancet* (see box). The series is supported by a call to action issued by the WHO Director-General, Dr Margaret Chan and the UNICEF Executive Director, Dr Anthony Lake, rallying countries and all concerned partners to accelerate implementation of integrated strategies and coordinated approaches for ending preventable deaths from pneumonia and diarrhoea.

An advocacy and communications working group with members from WHO and 12 other organizations was established to increase awareness of the issues and solutions relevant to pneumonia and diarrhoea control, and to sensitize decision-makers. A joint communiqué by USAID, UNICEF and WHO calls for close collaboration between all partners, using to the fullest extent possible existing country-level opportunities. Examples include national events to promote A Promise

“The Lancet Series on Childhood Pneumonia and Diarrhoea, led by Aga Khan University, Pakistan, provides evidence for integrated control efforts for childhood pneumonia and diarrhoea. The first paper assesses the global burden of these two illnesses, comparing and contrasting them, and includes new estimates of severe disease and updated mortality estimates for 2011. Findings from the second paper show that a set of highly cost-effective interventions can prevent most diarrhoea deaths and nearly two thirds of pneumonia deaths by 2025, if delivered at scale. Furthermore, the paper estimates what the cost of scale up will be. The third paper presents the results of consultations with several hundred frontline workers in high-burden countries and explores the barriers and enablers they face in dealing with these two diseases and potential ways forward. The final paper represents a call to action and discusses the global and country-level remedies needed to eliminate preventable deaths from these illnesses by 2025.” (<http://www.thelancet.com/series/childhood-pneumonia-and-diarrhoea>)

Renewed, actions related to the UN Commission on Life-Saving Commodities, and the introduction of new vaccines including pneumococcal and rotavirus.

Partners are jointly supporting selected countries to implement innovative models for the integrated delivery, at district level, of interventions on immunization, nutrition, case management and water and sanitation. In Bangladesh and Zambia, for example, MCA and the WHO Department of Immunization, Vaccines and Biologicals assist district health managers to include a comprehensive set of GAPPD interventions in district health plans. The Program for Appropriate Technology in Health (PATH) helps Burkina Faso and Nigeria better understand consumer knowledge, attitudes and practices related to treatment. UNICEF is leading a two-year initiative in Ethiopia, Kenya, Niger, and the United Republic of Tanzania to increase demand for ORS, zinc, and antibiotics, and to ensure that communities have access to a reliable supply of effective treatments. The Zinc Alliance for Child Health is using a public-private partnership to improve access to and use of zinc and ORS in three states of India: Uttar Pradesh, Madhya Pradesh and Odisha.

Handbook to plan community child health: MCA, in collaboration with UNICEF, USAID, Save the Children and other partners developed a handbook to support countries in introducing and scaling up community-based interventions. This handbook promotes planning for the implementation of three WHO-UNICEF training packages contained in *Caring for Newborns and Children in the Community: Caring for the newborn at home, Caring for the child's healthy growth and development* and *Caring for the sick child in the community*. It aims to:

- inform managers and planners about *Caring for Newborns and Children in the Community*;
- guide them in selecting the best mix of community-based interventions and packages for their country;
- guide them through key issues and decision points in planning and implementing the packages, in the context of ongoing country activities.

The handbook is organized around eight components of community child health: (1) organization, coordination and policy setting; (2) human resources; (3) supply chain management; (4) service delivery and referral; (5) sensitization and advocacy, community mobilization and participation, and promotion of recommended care practices; (6) supervision and quality assurance; (7) health information systems, monitoring, evaluation and research; and (8) budgeting, costing and financing.

Increased global attention to early child development (ECD) and nutrition: Children are extremely receptive to external influences, whether these promote their health and wellbeing or arrest and distort their development. Globally over 200 million children under five do not reach their development potential. This massive number of children is deprived of their right to health care, food, love and protection. Strategies to promote child development can easily be integrated into health, education and social and child protection programmes. Three areas are critical foundations for healthy child development: stable, responsive and nurturing caregiving with opportunities to learn; safe, supportive physical environments; and appropriate nutrition.

WHO promotes ECD through an approach that binds many different departments, including those responsible for maternal and child health, for nutrition, for mental health, violence and injury prevention. The approach, known as *Care for development*, assists families to be sensitive to the child's needs and to respond appropriately. Through simple interactions such as play and communication, it promotes children's growth and development; in addition it reduces mental stress and illness, particularly among women.

In January 2013, WHO hosted a meeting to review the evidence of effective interventions and programmes to promote early child development, with a particular focus on the role of the health sector. Participants urged WHO to exert leadership on four sets of actions, all of which are subsequently in progress:

- developing a joint statement on early child development that specifies effective interventions and unites inputs from multiple sectors around a common approach;
- defining population-based indicators and a framework for assessing the burden of sub-optimal development and tracking progress over time;
- building capacity in countries to integrate effective interventions, including care for development, into a harmonized approach that capitalizes on the strengths of the health, protection and education sectors;
- identifying research priorities for early child development, and investing in studies to strengthen the programmatic evidence.

A commentary published by the WHO Director-General in *The Lancet* drew the attention of a wide external audience. Dr Chan argued that ECD is essential for sustainable development, and the time is right to position it within the post-2015 agenda. Similarly, the sessions on early child development co-organized by MCA during the International

Work progresses on developing indicators for early child development. A background paper was prepared in December 2013; a wide consultation will take place in early 2014. Indicators will be identified in the following areas:

- Child development and learning, including cognitive (e.g. math and language), psychomotor, social/emotional and physical development
- Stunting
- Child maltreatment
- Early childhood care and education experience at the start of first grade
- Primary school access and learning
- Maternal depression
- Appropriate, responsive caregiving and a stimulating home environment
- Birth registration

Congress of Paediatrics in Melbourne in August 2013 gained significant international attention. As a result, *The Lancet* offered to prepare a third series on ECD for publication in September 2014; WHO convened the Steering Team and is acting as secretariat.

MCA worked with the WHO Department of Nutrition for Health and Development to prepare a supplement to the journal *Maternal and Child Nutrition* on promoting healthy growth and preventing childhood stunting. The supplement was launched at the International Congress of Nutrition, in Granada, Spain in September 2013. The series of articles presents the rationale for the global goal to reduce stunting, a conceptual framework centred on stunted growth and development, evidence of the feasibility of increasing adult height within one generation, and programmatic guidance. Throughout the supplement the authors emphasize the need for nutrition-specific and nutrition-sensitive interventions, and the role of multiple sectors. The supplement is supported by video summaries of each paper; these can be accessed at http://www.who.int/nutrition/healthgrowthproj_maternalchildnut_journal_video/en/.

FIGURE 5 **The care for development intervention: example of simple, effective child–caregiver interactions in three age groups**

Age 1 week up to 6 months ▶
Talk to your child and get a conversation going with sounds or gestures (copy your child).





◀ Age 12 months up to 2 years:
Give your child things to stack up, and to put into containers and take out.

Age 2 years and older ▶
Help your child count, name, and compare things. Make simple toys for your child.



Investing in the health of adolescents

HIGHLIGHTS OF 2012–2013

- ✎ Guidelines on HIV testing and counselling for adolescents, and care for adolescents living with HIV
- ✎ Preparation of *Health for the world's adolescents*:
 - Photo competition for and by adolescents
 - WHO recommendations of interventions for adolescents
 - How-to document “Making health services adolescent friendly”
- ✎ Potential conjunct interventions for delivery with HPV vaccination
- ✎ Research priorities for adolescent sexual and reproductive health
- ✎ Resource needs for scaling up adolescent-friendly health services
- ✎ Comparison of data on maternal mortality among adolescents and among older women

Guidelines on HIV testing and counselling for adolescents, and care for adolescents living with HIV: HIV remains a key health concern for adolescents. Indeed, it is now the second most important cause of death among adolescents globally. Alarmed by the inadequate coverage of HIV testing and counselling for this age group, and the reported lacunae of care for adolescents living with HIV, MCA joined with the WHO Department of HIV/AIDS to develop relevant guidance. Recommendations were based on systematic reviews, and on expert and community consultations; guidelines were released on World AIDS Day 2013. An interactive web-based tool developed to assist in the implementation of the guidelines is available at www.who.int/adolescent/hiv-testing-treatment.

Key messages from the new guidelines include:

- The HIV epidemic among adolescents needs more attention and a tailored response.
- Issues and services for adolescents should be included explicitly in national HIV responses, policies and plans.
- Different subpopulations of adolescents may need different approaches to service delivery.
- National laws and policies on consent to services should be reviewed to reduce barriers to, and increase uptake of services by adolescents.
- Adolescents need increased access to testing through provider-initiated testing and counselling in health services in all high HIV-prevalence countries, and through community-based services for adolescents in all settings.

- Subsequent to HIV testing, there must be effective linkage to prevention, treatment and care services.
- Adolescents need increased access to ART and improved support to remain in care and adhere to treatment.
- Adolescents should be involved in the development of appropriate and effective HIV services.

Preparation of ‘Health for the world’s adolescents’, the first WHO publication to focus explicitly on the role of the health sector in improving and maintaining the health of this age group:

- A photo competition was opened to adolescents, aged 14–19 years. Seventy-seven adolescents from 33 countries in all WHO regions submitted a total of 450 photographs. Five professional photographers and a medical doctor judged the photos, ultimately selecting ten winners from Argentina, Brazil, India, Malawi, Pakistan, Philippines, Slovenia, Ukraine and the United States of America. The winners have taken photographs for inclusion in the report, to depict the following themes from their countries and perspectives:
 - adolescents are healthy;
 - adolescents learn about health;
 - adolescents use health services when needed;
 - it can be difficult to stay healthy;
 - adolescents are active in promoting health.
- A list of interventions recommended by WHO for delivery at primary and referral level has been put together. These address adolescent health from a life course perspective: some interventions deal with issues that adolescents would present to health care providers, while others contribute to the prevention of future conditions. While the list will need to be adapted to reflect the priority health concerns of adolescents and the resource constraints within each country, it provides a useful menu of interventions from which countries can choose.
- The report will contain a comprehensive global picture of the health of adolescents, including regional trends on adolescent mortality, disability-adjusted life years (DALYs) and some health-related behaviours.
- *Making Health Services Adolescent Friendly* was launched. This publication outlines the process of developing national standards of health service delivery for adolescents. A review of the standards from 27 countries that have followed this process resulted in a set of model global standards, to be presented in the report.

In order to ensure the age-specific data needed to identify and resolve barriers to improved service delivery for adolescents, UNAIDS and WHO have agreed to make such age disaggregation a standard feature of analysis and advice to countries.

Potential conjunct interventions for delivery with HPV vaccination: Girls aged 9 to 13 years, the target for the HPV vaccine, have few contacts with the health system. Vaccination provides an entry point for other services and an excellent opportunity for integration. WHO reviewed the potential interventions that can be delivered in combination with HPV. Selection criteria included public health relevance; duration of the intervention (shorter than 6 months, in order to fit within the 6-month vaccination schedule); appropriateness for the age group for both girls or boys; quality of the evidence of the effectiveness of the interventions in low- and middle-income countries;

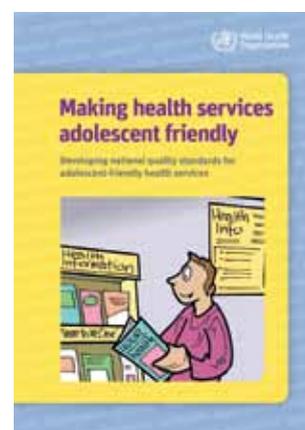




Photo from one of the ten winners in the competition for ‘Health for the world’s adolescents’ (Kachingwe, 14, Malawi)

and the programmatic feasibility of simultaneous delivery. Three types of interventions were particularly effective. Iron supplementation reduced anaemia. Promotion of physical activity improved activity rates, reduced weight and blood pressure. Sexual and reproductive health education, HIV prevention, and condom promotion interventions improved knowledge and intentions. Eighteen countries with HPV demonstration programmes are identifying opportunities to link HPV with other interventions for adolescents.

Research priorities for adolescent sexual and reproductive health: MCA sought input from nearly 300 researchers, programme managers and donors. These experts, representing all geographic regions and a range of background and experiences, ranked outcome areas, generated and prioritized research questions. Seven outcome areas were agreed: 1) maternal health, 2) contraception, 3) gender-based violence, 4) HIV treatment and care, 5) abortion, 6) family planning and HIV integration and 7) sexually transmitted infections. There was a high degree of consensus on the most important research questions in each of the seven areas. Many of the highly ranked questions reflect a movement towards the scaling-up of existing interventions and the development of new interventions. The results of this work, published in the *Bulletin of the World Health Organization*, will help guide donors and programme managers to prioritize funding decisions in adolescent sexual and reproductive health research.

Resource needs for scaling up adolescent-friendly health services: MCA carried out an estimation of the additional resources required to scale up adolescent-friendly health services. Results showed that the costs of achieving universal coverage in 74 low- and middle-income countries come to an additional US\$ 15.41 billion for the period 2011–2015, increasing from US\$ 1.86 billion in 2011 to US\$ 4.31 billion in 2015. This corresponds to approximately US\$ 1.02 per adolescent in 2011, increasing to \$4.70 in 2015. These estimates demonstrate a substantial gap and are indicative of the additional investments needed.



Photo from one of the ten winners in the competition for ‘Health for the world’s adolescents’ (Khatri, 17, India)

Comparison of data on maternal mortality among adolescents and among older women:

Adolescents are often assumed to have an increased risk of death during pregnancy or childbirth compared with older women, but the existing evidence is inconsistent and in many cases contradictory. MCA worked with the WHO Department of Reproductive Health and Research (RHR) and external researchers to quantify the risk of maternal death among adolescents by estimating maternal mortality ratios for women aged 15–19 years by country, region, and globally. These ratios were then compared with those for women in other 5-year age cohorts.

Findings showed a slightly increased risk of mortality in adolescents compared with women aged 20–24 years; the highest risk was in women older than 30 years. This suggests that the excess mortality risk to adolescent mothers might be lower than previously believed. However, these findings should not divert attention from efforts to reduce adolescent pregnancy, which are central to the promotion of women’s educational, social, and economic development.

Ensuring the application of newborn, child and adolescent rights

HIGHLIGHTS OF 2012–2013

- ✎ General Comment adopted on the right of the child to enjoy the highest attainable standard of health
- ✎ Child mortality studied as a human rights concern

General Comment adopted on the right of the child to enjoy the highest attainable standard of health: In 2012, MCA led WHO input to the development of a General Comment on the child's right to the highest attainable standard of health, as requested by the United Nations Committee on the Rights of the Child. The General Comment was guided by the Committee and prepared in close collaboration with UNICEF, Save the Children and World Vision International; the Committee adopted it in February 2013. The Comment articulates the content of the child's right to health, and outlines the relevant core obligations of governments and other stakeholders. It provides an important entry point for increased utilization of UN treaty monitoring bodies for rights-based monitoring and evaluation. In addition, it provides a normative and legal framework for systematically applying human rights standards in ongoing and future efforts to improve planning and programming for newborn, child and adolescent health in countries. In this context, in November 2012 and March 2013, MCA organized two orientation workshops on the General Comment for selected countries in the regions of South East Asia/Western Pacific and the Americas.

MCA is also preparing tools to provide countries with practical means to apply human rights standards to planning and programming for newborn, child and adolescent health. These tools, including a rights-based rapid assessment of maternal, newborn and child health laws, policies and programmes, and a rights-based evaluation of hospital care for children will help countries to put into practice the normative documents adopted by the UN Committee on the Rights of the Child and the UN Human Rights Council, as described above.

Child mortality studied as a human rights concern: In 2012, following strong support from MCA and RHR, the UN Human Rights Council adopted a Technical Guidance document on the application of a human rights-based approach to eliminate preventable maternal mortality and morbidity. To ensure that the Council provides similar attention to newborn and child mortality, MCA led informal discussions with key members; subsequently formal action was taken, supported by WHO, UNICEF, the Office of the High Commissioner for Human Rights (OHCHR), Save the Children and World Vision International. A full-day high-level discussion on children's right to health ensued at the Council session in March 2013, after which the Council invited WHO to prepare a study on under-five mortality as a human rights concern. The Council welcomed the report at its session in September 2013, and adopted a thematic resolution on under-five mortality in which it requested the OHCHR, in close collaboration with WHO, to prepare relevant technical guidance. MCA is leading the WHO contribution to this guidance.

Supporting global initiatives

HIGHLIGHTS OF 2012–2013

- ✎ Commission on Information and Accountability for Women's and Children's Health
- ✎ UN Commission on Life-Saving Commodities for Women's and Children's Health
- ✎ The Child Survival Call to Action: A Promise Renewed
- ✎ Countdown to 2015
- ✎ H4+ partnership
- ✎ RMNCH coordination mechanisms

Numerous global initiatives were launched in 2012 and 2013 to reinforce and accelerate progress towards achieving MDGs 4 and 5, and beyond. The following section describes the contribution of MCA to a selected number of these.

The Commission on Information and Accountability for Women's and Children's Health (CoIA): Under the umbrella of the UN Global Strategy for Women's and Children's Health, WHO was tasked with coordinating the Commission on Information and Accountability. Among the recommendations in the Commission's 2011 report is the development of country accountability frameworks, and MCA has provided significant support to translating that recommendation into action. To date, 68 of the 75 high-burden countries have completed or are in the process of completing accountability frameworks. The process has been instrumental in bringing together donors and country stakeholders and in strengthening International Health Partnership (IHP+) processes. It has also generated high levels of demand from countries for resources and technical support to implement the actions contained in their frameworks.

The UN Commission on Life-Saving Commodities for Women's and Children's Health was formed in 2012 as part of the Every Woman Every Child movement, to increase access to and use of appropriate medicines, medical services and health supplies. This Commission identified a set of 13 essential commodities across the reproductive, maternal, newborn and child health continuum of care, and made recommendations for getting those commodities to those who need them most. The Commission's report proposed the main ways to address barriers and to achieve the following for each of the 13 commodities: (1) improved markets (2) improved national delivery systems; and (3) improved integration of the private sector and consumer needs. In close coordination with UNICEF and UNFPA, WHO/MCA provided policy, regulatory and technical input to eight pathfinder countries to develop their plans for implementing the recommendations. The WHO Model List of Essential Medicines was updated and includes clarifications on the use of chlorhexidine in post-partum care, as well as a listing of antenatal corticosteroids. Treatment guidelines on newborn care were updated, and a guideline compendium was prepared and made

available to ministries of health and partners in an effort to increase access to updated information.

The Child Survival Call to Action: A Promise Renewed, proposes that every country reduce child mortality to 20 child deaths or less per 1000 live births by 2035. The GAPPD and the ENAP (described earlier in this report) provide interventions and targets that are compatible with this initiative.

Countdown to 2015 is a global movement of academics, governments, international agencies, health-care professional associations, donors, and nongovernmental organizations. Members of this movement are committed to increasing the engagement of all key stakeholders in the 75 high-burden countries in the use of evidence to promote accountability and accelerate progress towards MDGs 4 and 5. MCA is active in the leadership and technical working groups, and leads the working group on policy and health systems. It also leads the Country Working Group, in collaboration with staff of the London School of Hygiene and Tropical Medicine. In order to identify factors that have enabled some countries to make substantial progress towards MDGs 4 and 5, MCA led the preparation of a policy compendium and a set of tools for analysing national policy and health systems environments. The report *Accountability for Maternal, Newborn and child survival: the 2013 update* describes the progress and pitfalls in the work towards achieving the MDGs as measured against the CoIA indicators. The data were presented at multiple occasions in 2013, including the Women Deliver Conference in Kuala Lumpur, and events organized around the UN General Assembly.

To help build country capacity in the use of data to promote action, accelerate progress, and foster accountability, MCA and Countdown partners convened a workshop directly following the Women Deliver Conference. Over one hundred participants, working in country teams, reviewed their country's Countdown profile, and learned how to use it for education and advocacy. They also learned about the "Country Countdown", a multi-stakeholder process to use data on reproductive, maternal, newborn and child health (RMNCH) to improve decision-making and accountability. They received tools and guidance for developing profiles and scorecards, organizing relevant events, and mobilizing media, policy, and political attention. Subsequently a number of countries including Afghanistan, Pakistan, Peru and the United Republic of Tanzania have embarked on in-depth country case studies.

The **H4+ partnership** comprises the six multilateral agencies that are the lead technical partners for implementing the UN Global Strategy for Women's and Children's Health: UNAIDS, UNFPA, UNICEF, UNWomen, WHO and the World Bank. As the constituency with the most extensive reach in low-income/high-burden countries, the H4+ agencies have committed to facilitating implementation of the commitments made to this Strategy.

WHO and MCA contribute actively to this partnership, using the Organization's comparative advantage at all levels. Actions include:

- providing expert review and advice to countries as needed and requested, including for development of costed national plans;
- developing norms, standards and guidelines for scaling up quality health services;
- strengthening monitoring and evaluation systems.

Through WHO and partners, activities supported by the H4+ receive targeted funding from three specific donors: Canada, France and Sweden.

1. Since 2010, joint H4+ support, funded by the Government of Canada, has assisted five countries (Burkina Faso, DRC, Sierra Leone, Zambia and Zimbabwe) to accelerate

existing efforts by targeting implementation bottlenecks and gaps. Specifically, the objectives are to:

- provide joint support for national scale-up of integrated, RMNCH interventions with a focus on equity;
 - support the strengthening of national health systems, ranging from stewardship through to implementation and monitoring;
 - collect and analyse data to identify, document and support innovative approaches.
2. The support offered by the Government of France, as part of its commitments under the Muskoka Initiative, provides a unique opportunity to strengthen collaboration among four UN agencies (WHO, UNICEF, UNFPA and UNWomen), five technical areas within WHO, and the three levels of the Organization. The grant supports accelerated actions towards the achievement of MDGs 4 and 5 in Benin, Burkina Faso, Côte d'Ivoire, DRC, Guinea, Haiti, Mali, Niger, Senegal, and Togo. MCA was responsible for the development of the original proposal in 2011, and ensured inter-agency coordination by presiding the technical committee during the first two years of implementation.

The five WHO technical areas are: maternal and perinatal health (improved quality of care, particularly emergency obstetric and newborn care, quality assessments, and establishing MDSR); integrated community case management of childhood illness (increased coverage of and access to care for childhood pneumonia, diarrhoea and malaria); family planning (better access to and quality of services, resulting in increased demand and reduced unmet need); human resources (coherent human resource plans for RMNCH, with an emphasis on midwifery); and essential medicines (improved access to and better use of those medicines and supplies needed to support maternal, newborn, child health and family planning).

3. The Government of Sweden recently began providing support to implementing the commitments to the UN Global Strategy for Women's and Children's Health in Cameroon, Côte d'Ivoire, Ethiopia, Guinea-Bissau, Liberia and Zimbabwe. MCA contributed to the development of the proposal and to the initial implementation, for which plans have been developed and approved in all countries.

Specific attention to the Eastern Mediterranean Region: In collaboration with UNICEF and UNFPA, WHO is working with ten high-burden countries in the Eastern Mediterranean Region: Afghanistan, Djibouti, Egypt, Iraq, Morocco, Pakistan, Somalia, South Sudan, Sudan and Yemen. A high-level meeting, 'Saving the lives of mothers and children: rising to the challenge', held in January 2013 in Dubai, United Arab Emirates, was attended by 150 participants, including ten ministers of health, as well as senior officials and leading figures from 22 member states of the Region, and key partners and stakeholders. Through the Dubai Declaration, countries expressed their commitments to implementing plans for maternal and child health, taking measurable steps to strengthen their health systems, and establishing sustainable financing mechanisms. In preparation for the meeting, a case was made for investing in maternal and child health, by indicating the price tag and impact of scaling up the needed newborn and child health interventions in each of the ten targeted countries. All ten countries subsequently developed acceleration plans for MDGs 4 and 5, focusing on increasing coverage of the key interventions, and on addressing inequities in maternal and child health.

RMNCH coordination mechanisms: Recognizing the need for a structure to help align major initiatives related to RMNCH, 21 stakeholders including WHO agreed to establish the RMNCH Steering Committee. The alignment facilitates sharing information on the

priorities, gaps, bottlenecks and needs of countries for ensuring effective support for service delivery; harmonizing funding for RMNCH; and identifying high-level global leaders and partners to be advocates. To support coordinated action at country level, the Steering Committee committed to the “RMNCH Country Engagement Approach” which, among other matters, clarifies the best use of selected RMNCH-related funding streams available to meet country gaps and priorities.

The Steering Committee is complemented by the RMNCH Trust Fund, a flexible and rapid source of funding that allows countries to address specific commodity-related barriers to scaling-up RMNCH services and to tackle broader bottlenecks. The Steering Committee, the Engagement Approach and the Trust Fund are supported by a Strategy and Coordination Team, to which MCA has seconded one staff person.

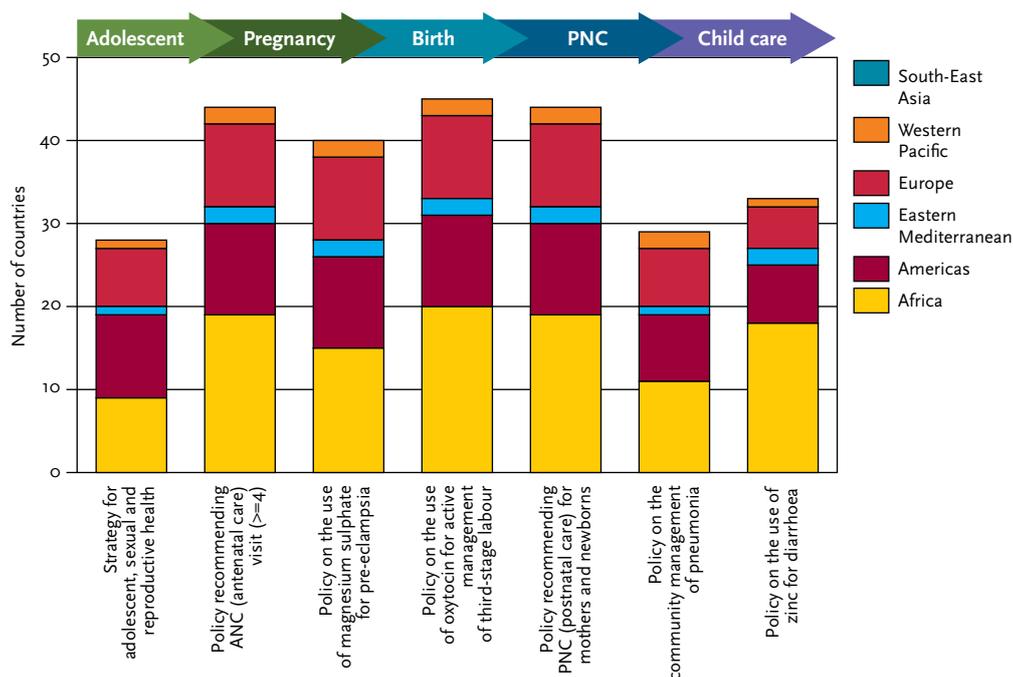
Monitoring country efforts to improve accountability

HIGHLIGHTS OF 2012–2013

- Key informant survey to track country progress
- Monitoring policies on home visitation programmes for postnatal care
- Workshops to strengthen accountability
- Policy compendium to support integrated planning
- Country Profiles for maternal perinatal, newborn, child and adolescent health
- Scorecards for reproductive, maternal, newborn and child health (RMNCH) and the African Leaders Malaria Alliance (ALMA)

Key informant survey: MCA uses a key informant survey to track country progress in developing or strengthening national policies along the continuum of care, and to monitor the inclusion of the latest WHO recommendations into existing national health policies. This survey is applied every two years.

FIGURE 6 Number of countries having adopted specific policy recommendations

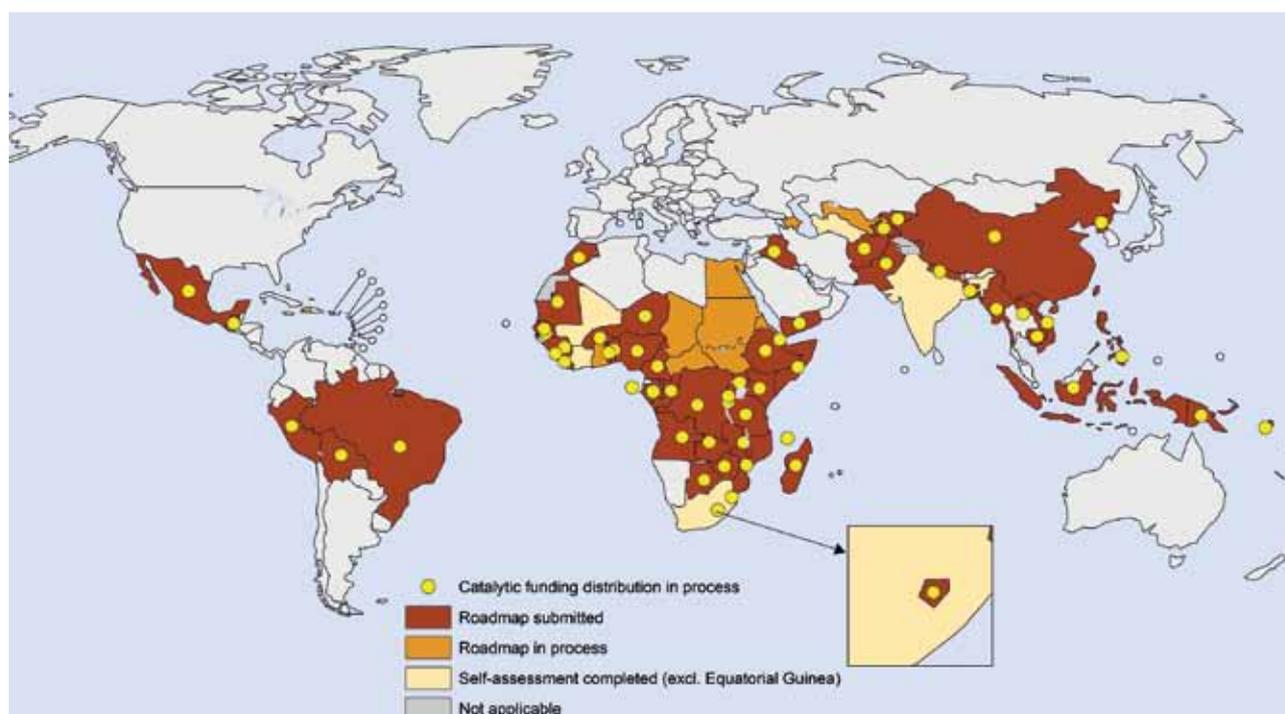


The first data were collected in late 2009/early 2010; a second set was collected in late 2011/early 2012. The third round of data collection began in late 2013; revised survey instruments incorporated earlier experiences as well as new global monitoring needs.

Monitoring policies on home visitation programmes for postnatal care: In 2009, WHO and UNICEF issued a Joint Statement recommending home visits for care of the newborn in the first week of life. Three years later, 30 out of the 58 countries of Africa and Asia have a policy on postnatal home visits. MCA documented the implementation of these home visitation programmes and the context of postnatal care in which home visits occur. Ways for increasing coverage of this effective intervention were identified that will guide policy makers and managers of maternal and child health programmes.

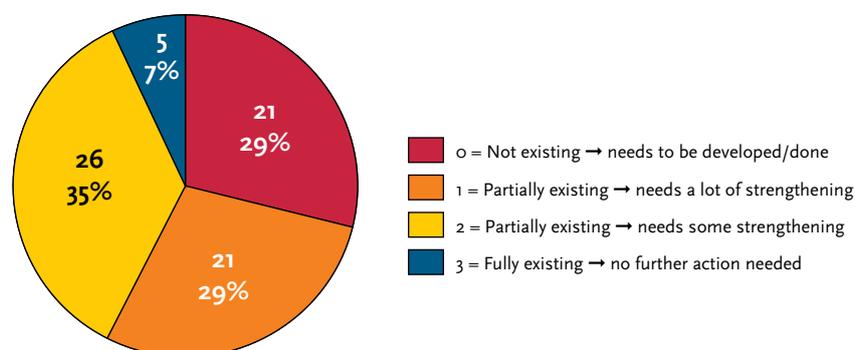
Workshops to strengthen accountability: In addition to the global monitoring of policy and health system indicators, MCA joined forces with other WHO departments and regional offices to facilitate a series of regional and country workshops. During these workshops, representatives of 74 countries used a standardized tool to assess the current situation related to accountability for health in their respective countries, and identified actions to strengthen relevant monitoring and evaluation activities (see fig 7).

FIGURE 7 **Country progress in strengthening results and accountability for women's and children's health**



Using the results of the two exercises described above, MCA performed a secondary analysis to map in detail the situation of countries in three areas: MDSR, ongoing monitoring activities, and periodic programme review mechanisms. The analysis was also conducted for global and regional levels. Results will inform the technical support that MCA can provide to help countries develop or strengthen their MDSR systems, programme monitoring and review mechanisms. Figure 8 shows the proportion of countries that consider themselves capable of implementing MDSR. A more complete summary of findings will be published in 2014.

FIGURE 8 Self-reported country capacity to review maternal deaths and respond (based on available data from 73 countries, 2012)



The recent multiplication of global initiatives has increased countries' burden of measuring and reporting, and reaching high response rates with quality data has become an important challenge. An interagency working group, led by the WHO Director-General, is working to resolve the issue.

The RMNCH Policy Compendium brings together the relevant evidence, policy recommendations and guidance for RMNCH interventions. It is the result of work led by WHO and the Partnership for Maternal, Newborn and Child Health (PMNCH), in collaboration with the H4+ partners, academia and professional associations. The Compendium is designed for policy-makers and managers who are responsible for developing, implementing and evaluating RMNCH strategies, plans and programmes, as well as those from other sectors that influence health-service delivery and RMNCH outcomes. It can be used either as an overall checklist for the RMNCH continuum of care, or to examine single selected policy topics (example: human resources) or technical areas (example: emergency obstetric care).

Country Profiles for maternal and perinatal health, newborn and child health, and adolescent health present a summary of the best existing national and sub-national information on the status of maternal and child health and on relevant health care issues. They are intended for use by decision-makers, programme managers, regional, national and sub-national authorities, as well as the general public. MCA country profiles are distinguished from others (e.g., countdown profiles, UNICEF profiles) by the inclusion of indicators that measure the quality of care, policy, and the use of WHO guidelines.

Updating of country profiles became easier and faster with the automated reporting system which was finalized in 2013. Country profiles are now available for all 75 high-burden countries for maternal, perinatal, newborn and child health; these will soon be accessible on the WHO/MCA website.

RMNCH national "scorecards" are a tool for summarizing country information on the 11 core CoIA indicators. These scorecards are available for each of the 75 high-burden countries.

For nine of the 11 indicators, the scorecards also show the subnational level variations in coverage. Subnational level data were obtained from the latest published Demographic and Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS). Columns are blank for indicators where data are not available more recently than 2005 (see link: http://www.who.int/maternal_child_adolescent/documents/countries/indicators/en/index.html).

FIGURE 9 Sample pages of country profiles

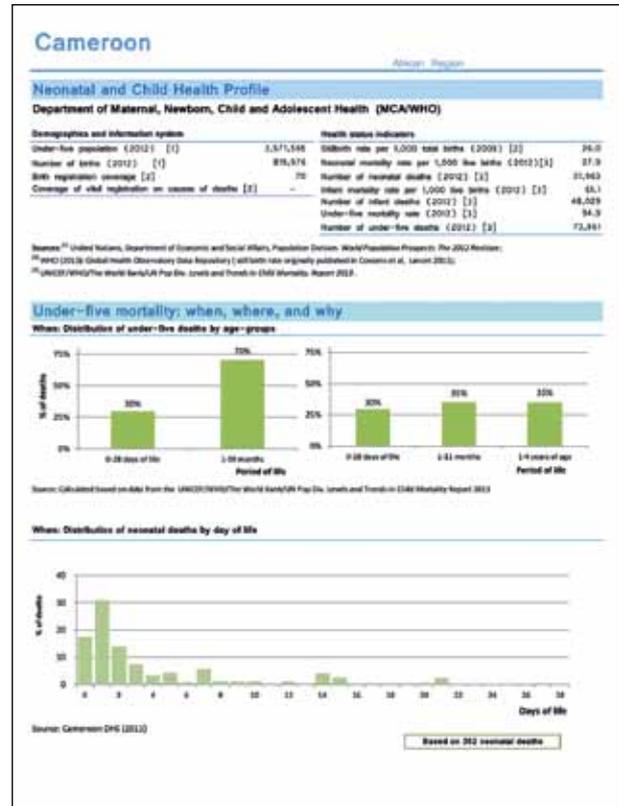
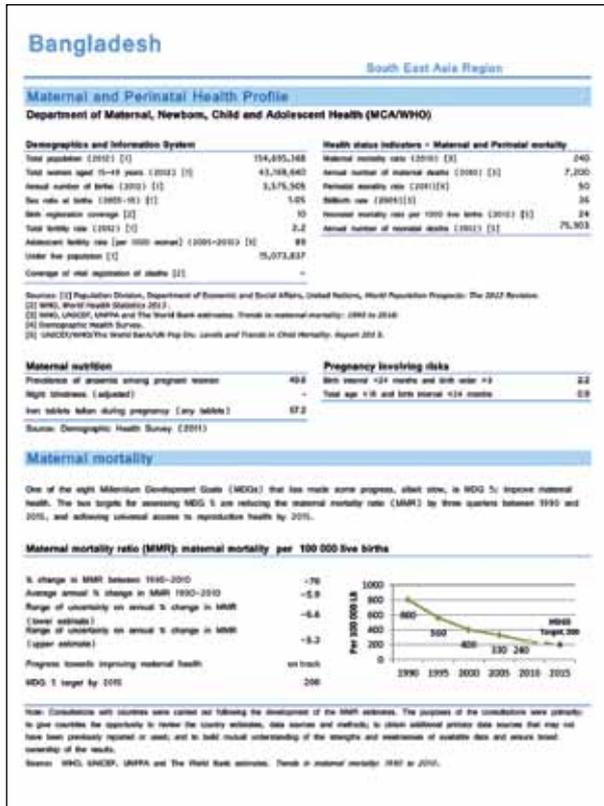
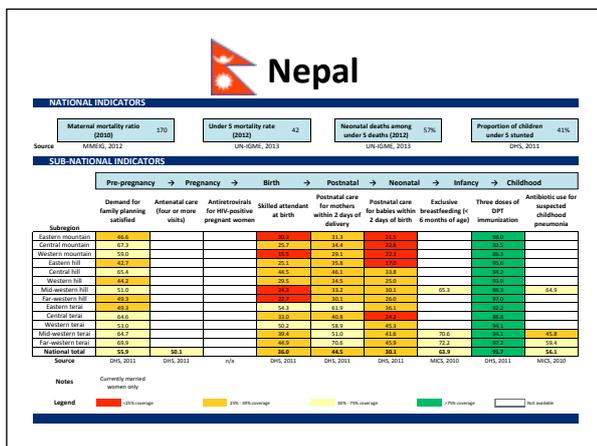


FIGURE 10 Sample RMNCH and ALMA scorecards



ALMA-WHO Scorecards for the African Region: The African Leaders Malaria Alliance (ALMA) worked with WHO to produce the ALMA scorecard. This scorecard presents data for 46 countries of the African region, and is updated quarterly. MCA is responsible for updating six RMNCH indicators. With support from the Regional Office for Africa and MCA, country offices are engaged in tracking the implementation of actions recommended in response to the scorecard.

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2013

Compilation of WHO recommendations on maternal, newborn, child and adolescent health
http://www.who.int/maternal_child_adolescent/documents/mnca-recommendations/en/

Comprehensive cervical cancer prevention and control. A healthier future for girls and women
http://www.who.int/maternal_child_adolescent/documents/cervical_cancer_prevention/en/

Counselling for maternal and newborn health care. A handbook for building skills
http://www.who.int/maternal_child_adolescent/documents/9789241547628/en/

Ending preventable child deaths from pneumonia and diarrhoea by 2025. The integrated Global Action Plan for Pneumonia and Diarrhoea (GAPPD)
http://www.who.int/maternal_child_adolescent/documents/global_action_plan_pneumonia_diarrhoea/en/

Levels and trends in child mortality 2013
http://www.who.int/maternal_child_adolescent/documents/levels_trends_child_mortality_2013/en/

Long-term effects of breastfeeding: a systematic review
http://www.who.int/maternal_child_adolescent/documents/breastfeeding_long_term_effects/en/

Maternal death surveillance and response: technical guidance. Information for action to prevent maternal death
http://www.who.int/maternal_child_adolescent/documents/maternal_death_surveillance/en/

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http://www.who.int/maternal_child_adolescent/documents/severe-acute-malnutrition/en/

WHO recommendations on postnatal care of the mother and newborn
http://www.who.int/maternal_child_adolescent/documents/postnatal-care-recommendations/en/

Women's and children's health: evidence of impact of human rights
http://www.who.int/maternal_child_adolescent/documents/women_children_human_rights/en/

2012

An equity-focused strategy to improve access to essential treatment services for children

http://www.who.int/maternal_child_adolescent/document

Born too soon: the global action report on preterm birth

http://www.who.int/maternal_child_adolescent/documents/born_too_soon/en/s/iccm_service_access/en/

Care for child development: improving the care for young children

http://www.who.int/maternal_child_adolescent/documents/care_child_development/en/

Caring for newborns and children in the community. Caring for the newborn at home

http://www.who.int/maternal_child_adolescent/documents/caring_for_newborn/en/

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http://www.who.int/maternal_child_adolescent/documents/adolescent_friendly_services/en/

Recommendations for management of common childhood conditions. Evidence for technical update of pocket book recommendations

http://www.who.int/maternal_child_adolescent/documents/management_childhood_conditions/en/

WHO recommendations for the prevention and treatment of postpartum haemorrhage

http://www.who.int/maternal_child_adolescent/documents/postpartum_haemorrhage/en/

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- The Partnership for Maternal, Newborn and Child Health
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