<u>SAVING CHILDREN UNDER-FIVE AND THEIR MOTHERS: The Only Innovation needed – Dedication:</u>

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Nearly 9 million children die every year before the age of five – that is nearly one child every three seconds. Just under 4 million of these children die within their first month during the newborn period. Nearly 3 million babies die within one week of birth, including up to 2 million who die in low or middle-income countries, - disproportionately from the poorest and most marginalized communities within those countries.[1] In Afghanistan, one child in five will die before their fifth birthday.[2] Across the whole of sub-Saharan Africa, the figure is one in seven.[3]

There is wide agreement about the actions needed to massively reduce levels of newborn and child mortality. The scandal is that governments and others with influence have failed so far to provide the leadership, resources and sense of urgency to make it happen. In the year 2000, world leaders committed themselves to Millennium Development Goal (MDG) 4, calling for a reduction by two-thirds, between 1990 and 2015, in the under-five mortality rates and to MDG 5 to reduce maternal mortality by three-quarters by the target date.

The theme of this panel is Opportunities for Innovation: Stakeholder Perspectives and Proposals. Innovation is an interesting word. To most it suggests new technology or new developments in drugs or approaches not used before. There are many examples of these: - Sprinkles micronutrient supplements developed by Canadian Sprinkles Global Health Initiative to prevent and treat micronutrient deficiencies among young children and other vulnerable groups at risk. New designs for compact easily deployed solar and wind generators. The use of PDAs to collect data in the field and to help trained community health workers stay connected to clinic and hospital staff. These kinds of innovations are important and INGOs will continue to seek new technology, new drugs, and new approaches. The most important innovation needed to save the lives of millions of children is the 'innovation' of dedication. It is unfortunate, but it is the lack of dedication to the funding of known preventions and treatments, the failure to scale up proven approaches, that has allowed the Millennium Development Goals to fall off track in so many countries.

Save the Children believes there should be a real drive to expand the coverage of proven integrated interventions that reduce maternal, newborn and child mortality. These include: skilled personnel available during pregnancy, childbirth and after delivery; preventive and curative treatment of pneumonia, diarrhea and malaria; and support for nutrition, including breastfeeding, complementary feeding, cash transfers and wider social protection programmes. These interventions should be delivered through stronger health systems, so that the poorest and most marginalized families can get the healthcare, nutrition and other services they need. Action should be matched by policies that address the underlying causes of child mortality. Policies to reduce newborn and child mortality must be flexible, as they need to be applied in fragile and conflict-affected states, as well as in chronic emergencies and rapid fast-onset disaster situations.

Given the difficult economic and environmental conditions the world faces, it would be easy to be pessimistic about the prospects of achieving MDGs 4 and 5. Yet, we know that a really dramatic reduction in the number of child deaths is achievable. We know it because many low and middle-income countries have cut mortality significantly over the last few decades, and many have done so more rapidly than today's developed economies managed in the last century.[4] Although further progress is needed, since 1990 more than 60 countries have reduced their child mortality rate by 50%. [5]

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[1] UNICEF (2008) *The State of the World's Children 2008:* pages 8-9
[2] *Ibid.* page 118
[3] World Health Organization (2009) *World Health Statistics 2009*
[4] H Rosling (2008) *Reducing Child Mortality,* Gapminder. Accessed 21 August 2009 at http://www.gapminder.org/video/gapcasts/gapcast-11-reducing-child-mortality/
[5] UNICEF (2007) *op cit:* page 9

Within the context of G8, much remains to be done for mothers, newborns and children. While we have seen reductions in mortality among children under the age of five, if we hope to meet MDG 4, , we have to focus on newborns, because the first month of life is crucial and is the time when children are most likely to die. At the same time, we must look towards ensuring that integrated and comprehensive services are provided for mothers within the continuum of care. G8 is a unique opportunity to build on past successes and evidence based findings to encourage leaders to pledge strong support towards MNCH issues.

Save the Children's EVERY ONE Campaign plans to address the issue of maternal, newborn and child mortality as a matter of public policy and public engagement and from a programming perspective. Maternal, newborn and child survival must be the key metric in measuring success in development. Save the Children has a seven-point plan.

1. Developing countries need to implement credible plans and no country with a credible plan should fail due to lack of resources. Donors and international institutions must support the efforts of these countries.

2. Focus on newborn babies and their mothers: Better pre, antenatal and postnatal care benefits not only the infant but the mother. The health needs of the mother and child must be met in the context of the Household to Hospital continuum of care.

3. Prioritize equity: Clearly the gaps in coverage of maternal, newborn and child health, nutrition and related interventions, as well as mortality rates between rich and poor must be addressed to have sustainable progress.

4. Mobilize additional resources: The cost of saving $1 million children is estimated to be $1 billion. For less than half of what world consumers spent on companion pet food in 2007[6] we could save the lives of 9 billion children. Additional resources are also needed if we are to reduce maternal mortality by ¾ by 2015 per MDG5. We need a rapid increase in international funding from governments, the private sector and individual donors.

5. Train and deploy more health workers: Part of the resources must be invested in the recruitment, training, equipping and deployment of health workers. Community volunteers can be employed as front line workers to help with public education and lactation support and basic diagnostics, trained midwives and traditional birth attendants can work under the direction of trained medical staff and can be linked to clinics and hospital via technology.

6. Tackle under-nutrition: Support should be provided to proven interventions including, exclusive breastfeeding, micronutrient supplements, complementary feeding and food fortification. What must not be forgotten is the success of cash transfers and social protection programmes to help stave off hunger and starvation. Accountability must be better addressed and developing and donor countries should report annually on their performance against the internationally-agreed nutrition indicator.

7. Increase focus on children in emergencies. The devastation in Haiti and the particular vulnerability of infants, children and mothers makes plain why more resilient systems must be developed to support and protect children in emergencies, and fragile and conflict situations.

[6] J Taylor (2009) Top 10 global pet food leaders – 2008 at http://www.petfoodindustry.com/ViewArticle.aspx?id=23600

Maternal, Newborn and Child Survival Strategies on the Ground

There are many obstacles to health care access for women and children in developing countries. Some of the main obstacles are long distances to health care services and hospitals and the cost of treatment. Both are addressed with the Household to Hospital Continuum of Care and the Community Case Management approaches to delivering care. If there is doubt as to why women simply have difficulty going to a health care facility Table 1 below makes it plain:

Table 1[7]

Time to Walk	Mother to Birth Attendant's House	Mother to Nearest Health Centre
Less than ½ hour	40.6%	11.4%
Between ½-1 hour	41.6%	17.8%
More than 1 h	16%	69%
Of those >1hr:		
1-2 h	15.9%	2.3%
2-3 h	56.8%	31.6%
> 3 h	27.3%	66.1%
Max. distance	6 hours	30 hours

1. Household to Hospital Continuum of Care Approach:

For every woman who dies in childbirth, 30 to 50 women suffer injury, infection or disease. These deaths and injuries - 99 percent of them in the developing world - leave newborns motherless and, as a result, newborns have fewer opportunities for education and good health and a higher likelihood of dying before the age of 2. The main causes of maternal death include: severe bleeding (mostly bleeding after childbirth), infections (also mostly soon after delivery), hypertensive disorders in pregnancy (eclampsia), and obstructed labor.

Save the Children has championed the Household to Hospital Continuum of Care (HHCC) strategy which strengthens the capacity of caregivers - whether in households, the community, health facilities, or hospitals - to manage normal maternal and newborn care, prevent and manage maternal and newborn complications, and provide prompt referral to the next level of care when complications arise. The HHCC approach helps to address the major causes of death before, during and after child birth for the mother as well as the causes of newborn mortality. Figure 1 outlines how the HHCC strategy works.

Save the Children has successfully strengthened the HHCC in several countries in Asia and Africa including Vietnam, Afghanistan, Pakistan, and Malawi. We hope to use the lessons learned, tools and methodologies in additional countries such as Mali, Ethiopia, Guinea, Uganda, Bolivia, Mozambique and Bangladesh.

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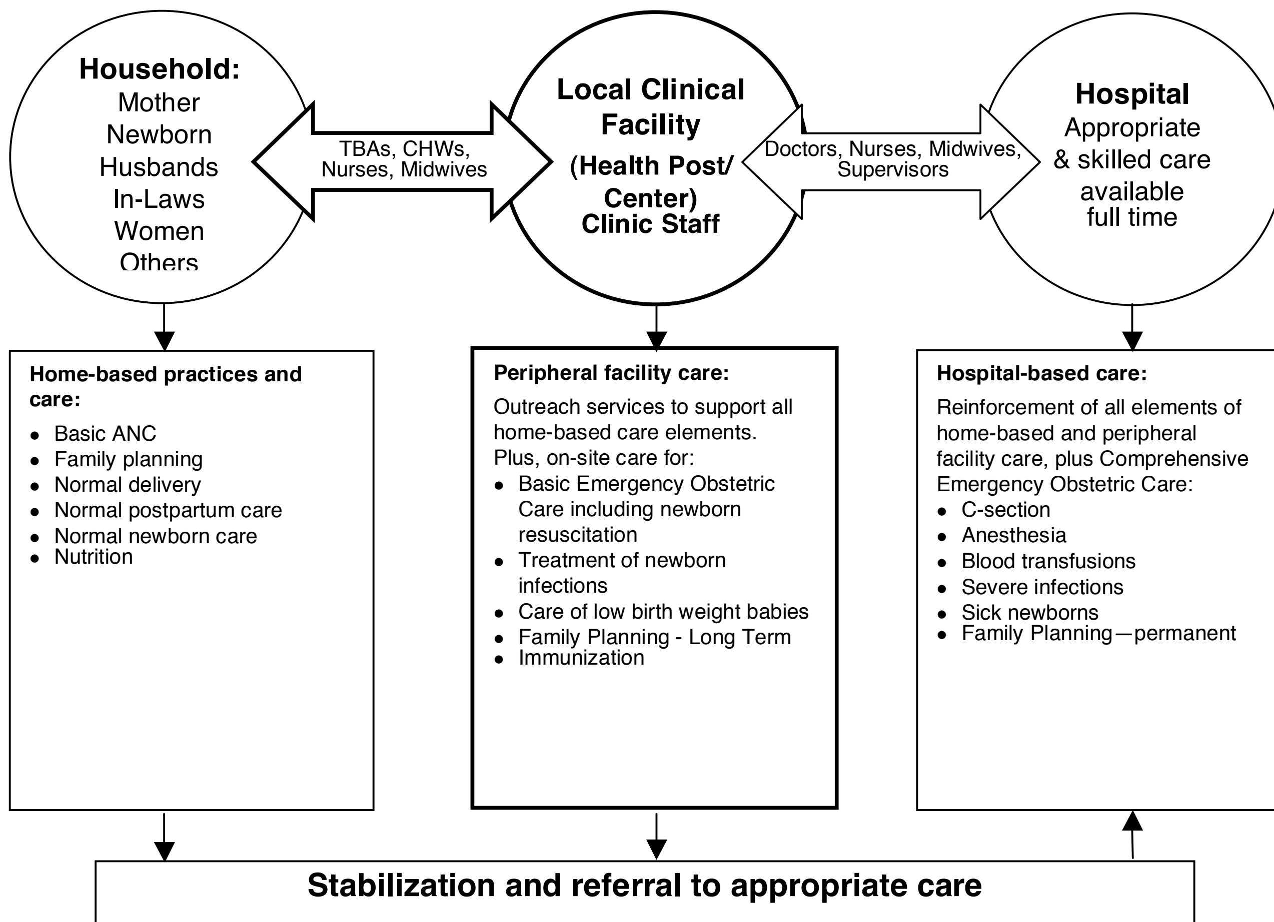
[7] D Hammer, Center for Global Health and Development, report on collaborative project between Lufwanyama DHMT, LUNESP Study Team and the Boston Center for International Health and Development

Figure 1[8]



2. Community Case Management

Save the Children has prioritized Community Case Management (CCM) as a global child health initiative to address the health needs of children under-five. CCM is a strategy in which trained community health workers deliver curative interventions for potentially life-threatening childhood infections in remote communities that lack access to health facilities. Interventions include oral rehydration and zinc for watery diarrhea; antibiotics for pneumonia, dysentery, and newborn sepsis; and anti-malarial drugs to combat one of the leading killers of infants and children.

Save the Children currently supports CCM in remote areas of 14 countries, with plans for six more. CIDA is currently funding Save the Children CCM programs in Malawi, Mozambique and Southern Sudan and has the potential to save children from dying from preventable and treatable diseases that can be effectively managed in the community setting. Pivotal to Save the Children's approach is the value placed in delivering services at the community level for mothers, newborns and children.

[8] M Powers, Save the Children, *Save the Children: 2009 Newborn Health Program Development report*

In a study of a Save the Children CCM project in Ethiopia, [9] the performance of volunteers in providing Community Case Management for diarrhea, fever and pneumonia in the Liben *Woreda*, Oromiya Regional State was evaluated. Save the Children supported Ministry of Health and communities to deliver child survival interventions from 1997-2006. Permission was obtained in 2005 to train 45 volunteers from remote *kebeles* in CCM. The strategy was evaluated through reviewing registers and supervision records; examining CCM workers; focus group discussions; and three household surveys. The CCM workers treated 4787 cases, mainly: malaria (36%), pneumonia (26%), conjunctivitis (14%), and watery diarrhea with some dehydration (12%). They saw 2.5 times more cases of childhood fever, pneumonia, and diarrhea than all the *woreda's* health facility staff combined. Quality of care was good. The availability, quality, demand, and use of CCM were high. These CCM workers were less educated and less trained than health extension workers who perform complicated tasks and dispense expensive anti-malarial drugs like Coartem®. The study showed that CCM workers should also treat pneumonia with inexpensive drugs like cotrimoxazole to help achieve Millennium Development Goal 4.

Conclusion:

The financial and ecological crises have demonstrated how interconnected and mutually dependent the lives of the world's 6.6 billion people have become. They also highlight the degree of global injustice. Nowhere is this inequity more egregious than in the deaths of millions of innocent newborn babies and children each year.

Today's developed countries have already cut their mortality rates dramatically over the course of the last century. Many developing countries have made huge strides, often in difficult circumstances. We do not need a major technological breakthrough to end this injustice. We merely need to learn from other countries' success, and apply proven remedies more systematically, and with greater urgency. The only innovation required is the dedication of adults around the world. The dedication to ensure that no child dies of preventable causes and that no woman should die simply because she is too far away or cannot afford to access health support before, during and after birth.

The death of millions of young children every year is a moral outrage, comparable to the worst abuses and social evils of the past. Every one of us has a role to play in tackling this problem. Further delay or inaction is inexcusable.

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[9] J.Health *Community Case Management Improves Use of Treatment for Childhood Diarrhea, Malaria <u>and</u> Pneumonia in a Remote District of Ethiopia* [*Ethiop.J.Health Dev.* 2009;23(1):00-000]