Towards a Grand Convergence for Child Survival and Health

A strategic review of options for the future building on lessons learnt from IMNCI

EXECUTIVE SUMMARY

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1. Over the past quarter century, child mortality has more than halved, dropping from 91 to 43 deaths per 1000 live births between 1990 and 2015. Yet in 2015 an estimated 5.9 million children still died before reaching their fifth birthday, most from conditions that are readily preventable or treatable with proven, cost-effective interventions. Given the stakes we, the global child health community, must do far better to assist countries to deliver the best possible strategies to help each child survive and thrive.

2. In 1995, WHO and UNICEF developed Integrated Management of Childhood Illness (IMCI) as a premier strategy to promote health and provide preventive and curative services for children under five in countries with greater than 40 deaths per 1000 live births. In 2003 care for newborns under one week of age was added and the strategy was renamed as IMNCI in many countries.[1] Over 100 countries have adopted IMNCI and implemented to varying degrees its three components: 1) improving health worker skills, 2) strengthening health systems and 3) improving family and community practices.

3. Twenty years later a stock-taking is warranted. Interest and funding for IMNCI have waned, implementation has proved problematic and coverage at scale was rarely achieved. With attention focused on specific child health areas such as immunization and communicable diseases, a holistic view of child health has arguably been lost inside the continuum of reproductive, maternal, newborn, child and adolescent health (RMNCAH). Nevertheless, IMNCI ushered in a transformation in how we view effective child health services. We now must build on lessons learnt to redesign the strategy, incorporating the latest evidence-based interventions and most effective delivery mechanisms, and integrating the rich repository of tools and resources that have become available since IMNCI was launched. We must also re-position IMNCI under the Sustainable Development Goals (SDGs) and the U.N. Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).[2] Our Review aims to maximize the potential of IMNCI to end preventable newborn and child mortality and help children thrive wherever they live, by supporting a seamless continuum of high-quality care spanning the home, community and health facility.

4. All countries have committed to reducing under-five mortality to 25 or less and newborn mortality to 12 or less per 1000 live births by 2030. These targets are ambitious yet achievable, provided there is political will, adequate investment and concerted action. To achieve a "Grand Convergence for child survival and health within a generation", we must strengthen health systems, build capabilities to meet children's health needs, and work towards universal health coverage. We have the knowledge, resources and opportunities to invest. What is required now is renewed energy to capture attention and mobilize action, maximizing funding from domestic, bilateral and multilateral sources including the Global Financing Facility (GFF).

5. The present Strategic Review brought together an independent expert advisory group with study group members at WHO and UNICEF to review past lessons and propose an agenda to stimulate momentum for improving care for children. The Review draws its conclusions from 34 unique sources of data, 32 of which were specifically commissioned. The data set represents contributions from over 90 countries and hundreds of experts in child health and related areas, and considers findings from a comprehensive review of the published and unpublished literature as well as in-depth case studies of implementation. Study group members used data to answer pre-defined questions and extracted key messages at

[1] We use the term IMNCI for consistency throughout this report, recognizing that newborn care was added at a later date.
[2] Hereafter referred to as the "Global Strategy".

participatory workshops; preliminary recommendations were then refined by a small group of high-level stakeholders representing global, regional and country levels. The findings of our review will be shared widely.

IMNCI implementation twenty years on

6. IMNCI was developed to increase coverage of evidence-based, high-impact interventions, taking an integrated approach to promotion, prevention and treatment and focusing on the top killers of children under five. IMNCI also represented a set of core values, by promoting a holistic, child-centred approach to childhood illness that sought to address basic human rights to health and health care. As such, IMNCI attempted to address the tension between selective and comprehensive approaches to primary health care and related questions around rights and programme expediency.

7. There has been near universal adoption of the IMNCI strategy by target countries, with widespread reported implementation of facility-based activities. Since 2010 there has been increasing implementation of integrated community case management (iCCM), building on WHO/UNICEF guidance and training materials. A 2016 Cochrane review found that IMNCI was associated with a 15% reduction in child mortality when activities were implemented in health facilities and communities. Other data have shown positive effects on health worker practices and quality of care. Improvements in care-seeking and household practices have been more rarely documented, as investment in community and home-based interventions has lagged. IMNCI's distillation of case management of the major killers of children under five years of age into a clinical algorithm and guidelines was highly appreciated by service providers and policy-makers for its simplicity and comprehensiveness, and it transformed how care for children is perceived at global and country levels.

8. However, IMNCI implementation suffered from a number of setbacks, with uneven implementation between and within countries, and insufficient attention to improvements in health systems and family and community practices. Countries and donors failed to agree on sustainable funding, and fragmentation of support by global partners led to a loss of IMNCI's built-in synergy around its three components. The fact that tools to support the health system and community components became available slowly and had variable uptake did not help countries build coherent programmes from the start. The emerging global attention to newborn mortality also contributed to a shift of focus in countries, with insufficient clarity on the complementary roles of maternal and child health units in addressing newborn health.

9. After IMCI was launched, WHO and UNICEF did not provide sufficient, sustained, focused global leadership, and too little attention was paid to programme monitoring, targets and operational research. Only countries with strong government leadership and political commitment were able to engage in the unified, country-led planning necessary to support scaling up. IMNCI was better implemented when: a) the health system context was favourable, b) a systematic approach to planning and implementation was used and c) political commitment allowed for institutionalization. The absence of an explicit emphasis on equity, community engagement and linkages to other sectors (for example education or water and sanitation (WASH)) were blind spots that limited IMNCI's contribution to reducing child mortality.

Looking forward: options for countries

10. Past experiences make clear that government ownership and government-led planning and implementation are required to scale up interventions and services – but that these depend on strong country leaders and disciplined partners. Child health stakeholders must work to mobilize political support in the context of a renewed focus on primary health care. Country actors and partners must reach convergence around an integrated, funded plan that aligns

maternal, newborn and child health programming under a common national vision, with specific national targets and monitoring to assess progress.

11. The highest-achieving countries in the era of the Millennium Development Goals (MDGs) were those that implemented tailored responses to the main bottlenecks to providing care for children. Countries must work with support from global partners to define strategies adapted to their epidemiological and health systems contexts, reviewing points of service and building on systems strengths. Examples include engaging the private sector to improve quality of care in countries with high rates of care-seeking in this sector, or adopting iCCM in contexts with low access to facilities and an existing cadre of CHWs. Integrated case management and delivery of interventions combining prevention and treatment remains the recommended approach for reasons of quality, effectiveness, efficiency and child rights.

12. District teams are the *sine qua non* of operational planning and implementation, and their efforts will be essential to improving quality of care. As such, IMNCI is a key element of both primary health care and universal health coverage. Resources for district teams must be mobilized including through advocacy at subnational level, alongside efforts to avoid rapid staff turnover and build up child health teams. Much greater attention must be paid to operational detail at district level, with improved data central to decision-making. Demonstration districts within countries can serve as laboratories to determine what works best, creating a learning system among district teams through which successful approaches can be generalized. Simultaneous monitoring can allow countries to quickly adjust course; active district child health committees comprising users, leaders and professionals can provide independent review.

13. Countries should explicitly prioritize reaching poor, under-served populations by using equity and mapping analyses to target service provision, and ensure free services for children at the point of care. Strategies to support households' capacity to produce health must be integrated into efforts to create a continuum of care for children at household, community and facility levels. To promote care-seeking and healthy practices, especially for newborns, countries should scale up evidence-based strategies for community engagement such as women's groups, accredited social health activists, home visits and health committees, linking these to ongoing monitoring to provide accountability for results.

Looking forward: child health at global level

14. Fragmentation of global child health efforts urgently needs to be resolved. Failure to coordinate on child health guidance and implementation has placed a large burden on countries with poor synergy among IMNCI's three components and led to inefficient use of funds. To facilitate greater coherence in response to country needs, it is imperative that global actors come together around a single unified vision and global architecture, within the frameworks of the SDGs and the Global Strategy (see global architecture as proposed in the diagrams on p. 5). WHO and UNICEF must lead this process. As part of this improved consultative process, a global expert advisory group should be established to systematically review technical and implementation guidelines in light of new evidence and provide recommendations for agreement among all concerned partners. This will also inform how donor investments are made.

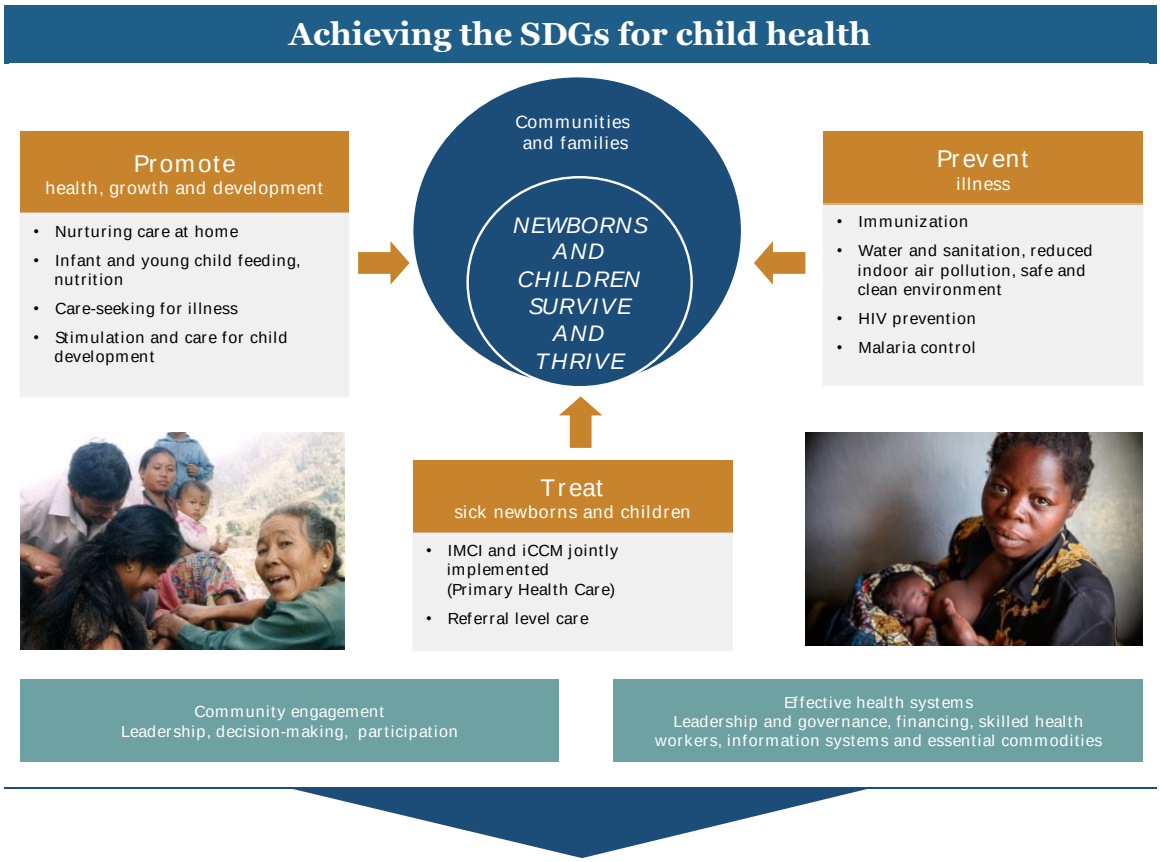
15. Whereas many interventions such as Stop TB, the Global Malaria Programme or the Expanded Programme on Immunization (EPI) are implemented as programmes, IMNCI has been promoted as a strategy. The resulting lack of specific and easily understood targets, budget lines and dedicated staff were noted as limitations by operational actors in countries. Global and country actors should clarify that implementation of a redesigned and repositioned IMNCI will follow a programme approach with a clear set of indicators, national and global targets and milestones to measure progress.

16. Current IMNCI guidelines and tools do not fully serve countries' needs in terms of flexibility, adaptability and user-centred design. With changing epidemiology and technological advances, there is not, and need not be, a "one size fits all" solution. A thoughtful harmonization and redesign of existing guidelines for interventions and delivery strategies will lead to a flexible menu of options, with guidance on creating context-specific packages while maintaining the holistic approach needed to achieve child health goals. To reduce the burden on countries, there is a need to refine existing and develop additional options for improving health worker skills including self-directed learning, distance learning, in-service training and improved pre-service training.

17. IMNCI must be repositioned in its role to accelerate progress towards the SDGs, the "survive and thrive" goals of the Global Strategy, and other global initiatives. Activities to save newborn and child lives are best undertaken in harmony with those to address maternal health, as evidence shows that at least 50% of the impact on newborn survival derives from interventions delivered to the mother, and in concert with activities around immunization, nutrition, malaria, HIV, tuberculosis, and water and sanitation. New investments under the GFF and from other sources will be needed to support these efforts and achieve implementation at scale. The integration and harmonization of existing packages can be done without losing the powerful brand of IMNCI, which enjoys widespread recognition and popular support.

18. Whichever convergence strategy is adopted, children and families must be placed at the centre, supported by global and national advocacy that fully engages communities and public opinion. Proactive participation and engagement by users and beneficiaries will be key to its success. Policymakers cannot be reminded too frequently about the importance of investing in child health and nutrition as a bedrock for economic development.

Recommendations



The global-level expert group responsible for the Strategic Review identified five main problems impeding the achievement of child health goals and improved care for children. Based on these findings, we recommend specific solutions for each problem, selected using the criteria that the solution be specific, feasible and actionable. Additional details and process indicators associated with each recommendation are provided in Annex 1.

Problem 1

Fragmentation of global strategies for child survival and health undermines country programming and limits potential impact.

Recommendation 1a: WHO and UNICEF immediately publish a joint statement repositioning IMNCI in the context of a package of care for the newborn and child spanning the home, community and health facilities, articulated within the framework of the Global Strategy, and have it endorsed by partners.

Recommendation 1b: All partners consolidate around a single leadership mechanism to coordinate implementation support for IMNCI at global, regional, and country levels, and work to harmonize activities with major funding structures including the GFF, the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), and the Vaccine Alliance (GAVI).

Recommendation 1c: Child health stakeholders in countries advocate for high-level representation in country coordinating mechanisms to 1) maximize effective coordination of partners' technical support and funding, 2) ensure integration of recommendations from the joint statement into national child health policies and
3) leverage investments in other sectors that can benefit child health.

Problem 2

The ambitious vision of the SDGs and universal access to quality health care will not be realized unless care for newborns and children is adequately funded and delivered to the most vulnerable and marginalized populations.

Recommendation 2a: Global partners develop innovative strategies to identify poor, under-served populations; target programme activities spanning the home, community and health facilities; and support equity-based policy actions such as removal of user fees.

Recommendation 2b: Child health leaders in countries mobilize political support and financial resources at national and sub-national levels using arguments about the value of investing in children's health, and use GFF investment cases to develop ambitious, costed child health plans and secure additional funding.

Recommendation 2c: WHO and UNICEF identify new, less resource-intensive approaches to training and supervision, such as self-directed learning, distance learning, clinical mentoring, and improved pre-service training, to reduce the financial burden on countries.

Problem 3

Evidence for the impact and effectiveness of interventions and delivery strategies is not systematically generated, captured and integrated into policy and programming.

Recommendation 3a: WHO and UNICEF establish a global expert advisory group to systematically review evidence and provide state-of-the-art recommendations on clinical interventions, delivery mechanisms and determinants of newborn and child health, and gain consensus on this process from major donors and governments.

Recommendation 3b: Global partners establish an online hub with 1) a repository of guidelines, tools, and documentation and 2) discussion forums to promote systematic south-to-south collaboration on operations research and sharing of best practices.

Recommendation 3c: Partners and stakeholders at regional levels link to the global expert advisory group to provide technical support and help countries translate guidance into policy.

Recommendation 3d: Country authorities integrate quality improvement methods and implementation science into programming and facilitate shared learning among district teams to allow local solutions to emerge and be generalized.

Problem 4	**Strategies and programmes for care of newborns and children are insufficiently tailored to countries' epidemiological and health systems contexts, and practice tools do not always respond to end users' needs.**

Recommendation 4a: WHO and UNICEF bring together existing guidance packages on care for newborn and child health into one set of flexible, adaptable, user-friendly tools, incorporating input from end users and design specialists.

Recommendation 4b: The global expert advisory group recommends additional strategies to build upon the efforts of diverse actors at country level, including the private sector, non-governmental organizations, professional associations, and other child health-influencing programmes and sectors, with a strong focus on community engagement.

Recommendation 4c: Governments and partners focus on combined interventions in districts to improve health workers skills, strengthen health systems, and strengthen community engagement and family practices.

Problem 5	**There is lack of accountability to populations and mutual accountability among partners, and a corresponding need for clear targets and strong monitoring at all levels.**

Recommendation 5a: WHO and UNICEF immediately establish a joint leadership process to develop and adopt clear IMNCI programme targets at global, regional, national, and sub-national levels and coordinate progress tracking with accountability processes under the Every Woman Every Child (EWEC) movement and the Global Strategy.

Recommendation 5b: Under the umbrella of joint leadership and in coordination with the Health Data Collaborative, partners strengthen country capabilities to routinely monitor and evaluate progress in child health, with a focus on both coverage and quality of care, and promote and support specific, well-designed systems for review and follow up, using scorecards to track progress.

Recommendation 5c: Country authorities scale up monitoring initiatives alongside a strong push for community engagement, providing communities with readily interpretable data on the availability and quality of child health services.