Managing Programmes to Improve Child Health

Overview

Department of Child and Adolescent Health and Development

World Health Organization

Outline of this presentation

- Current global child health situation
- Effective interventions to improve child survival & health
- Coverage of key interventions
- Key principles of intervention delivery
- Why are programme management guidelines needed?
- The target audience
- The objectives of this training course
- What this course covers

Read the text on the slide

Commitment to child survival and health

- There is unprecedented consensus on the Millennium Development Goals
  - MDG4 target: reduce under-5 child mortality by two-thirds between 1990 and 2015
- Convention on the Rights of the Child calls for
  - The right to life, survival and development (Article 6)
  - Best interests of the child (Article 3)
  - Non-discrimination (Article 2)

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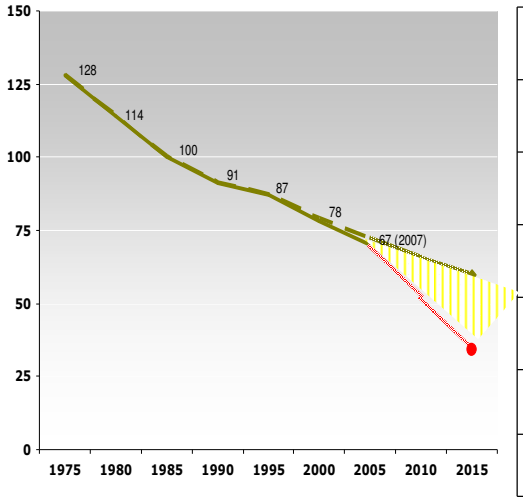
Child mortality

Source: World Health Statistics 2009 and WHO Mortality Database



1975	128
1980	114
1985	100
1990	91
1995	87
2000	78
2007	**67**

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This graph shows the global trends in child mortality since 1975. The current under-five mortality rate stands at 67 per 1000. If the trend seen in the 2000-7 period continues, it would be about 60 per 1000 in 2015 compared to the MDG4 target of 34 per 1000.

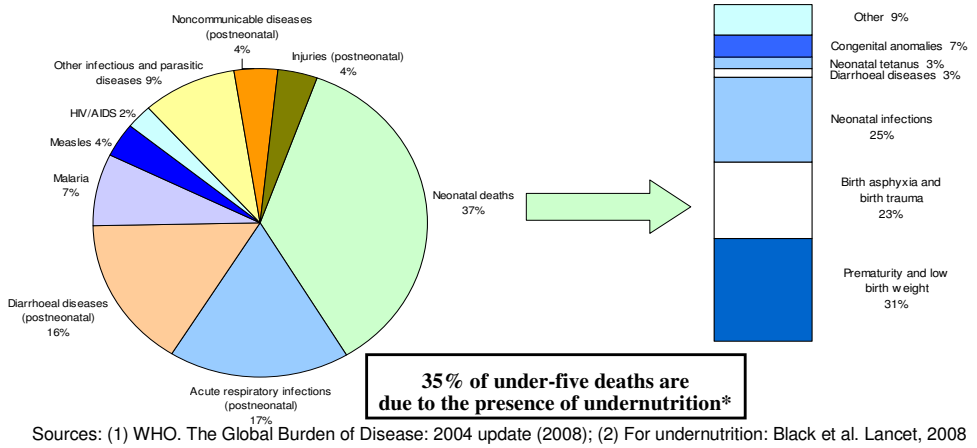
Child mortality trends

Source: World Health Statistics 2008 and WHO Mortality Database

Period	Annual change
1975-80	-2.2%
1980-85	-2.5%
1985-90	-1.8%
1990-95	-0.9%
1995-00	-2.1%
2000-07 (7 years)	**-2.0%**

The rate of decline in under-five child mortality was the highest between 1980–85 at about 2.5% per year but slowed down thereafter, reaching below 1% per year in 1990–5. The rate of mortality decline increased thereafter but has been about 2% between 1995–2007. In order to reach the MDG4 target of 34, this decline needs to be around 6% between 2006–2015.

Major causes of death in neonates and children under-five in the world - 2004



35% of under-five deaths are due to the presence of undernutrition*

Sources: (1) WHO. The Global Burden of Disease: 2004 update (2008); (2) For undernutrition: Black et al. Lancet, 2008

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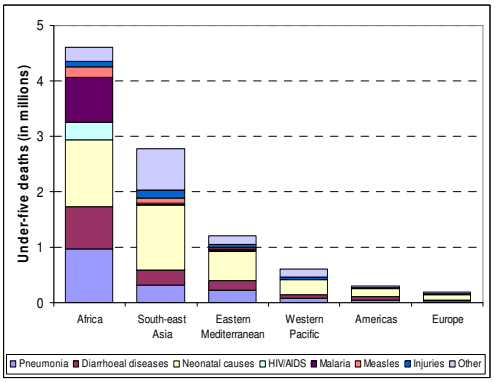
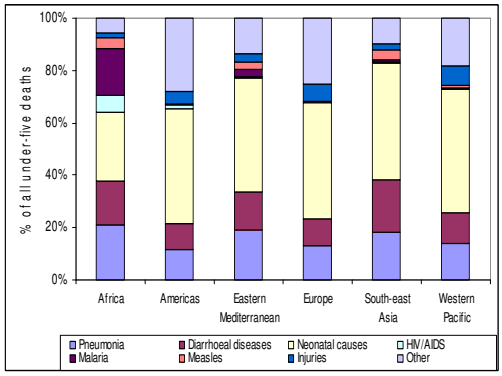
The two charts on this slide show the main causes of neonatal deaths and post-neonatal under-five deaths. Just three conditions – neonatal infections, birth asphyxia and preterm birth – account for three quarters of all neonatal deaths. Similarly, just four conditions – pneumonia, diarrhoea, malaria and measles – account for three quarters of under-five deaths beyond the neonatal period. The recent Lancet nutrition series authors estimated that about 35% of all under-five deaths are due to the presence of undernutrition.

Number, proportion and causes of under-five deaths in each WHO region



Source: CHERG/CAH/WHO (published in The World Health Statistics 2008): 2000 estimates of the distribution of causes of death; MHI/IER/WHO: 2006 estimates of number of deaths



Source: CHERG/CAH/WHO (published in The World Health Statistics 2008): 2000 estimates of the distribution of causes of death

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This slide demonstrates two important facts: First, under-five deaths are not evenly distributed across different regions of the world. Second, the relative importance of causes of death is somewhat different in different regions.

The graph on the left shows the number of deaths by region – showing that almost all of them occur in African, South-East Asian, Eastern Mediterranean and Western Pacific Regions, with about half of all global child deaths occurring in the African region alone. The graph also shows that the greatest number of child deaths due to pneumonia, diarrhoea, HIV/AIDS, malaria and measles occur in Africa while the greatest number of neonatal deaths occur in South-East Asia.

The graph on the right shows the relative proportion of pneumonia and diarrhoea deaths in African, South-East Asian and Eastern Mediterranean regions. Deaths due to neonatal, injuries and "other" causes are relatively more common in Americas, Europe and Western Pacific regions.

Effective interventions exist

- Over two-thirds of neonatal and older child deaths can be prevented with existing interventions
- Current coverage for these interventions is low, most between 30% and 50%

Source: Lancet series on Child Survival, Neonatal survival

Summarized in tables on pages 19-20 of Introduction module

Read the text on the slide

What are the most important interventions?

PREVENTIVE

- Skilled care at birth
- Postnatal care for all newborns
- Early initiation of breastfeeding
- Exclusive breastfeeding: 6 mo
- Complementary feeding
- Immunization
- Insecticide-treated bednets

TREATMENT

- Neonatal resuscitation
- Extra care of LBW babies
- Treatment of neonatal sepsis
- ORT and zinc for diarrhoea
- Antibiotics for dysentery
- Antibiotics for pneumonia
- Antimalarials

See more complete WHO/CAH list on page 17-18

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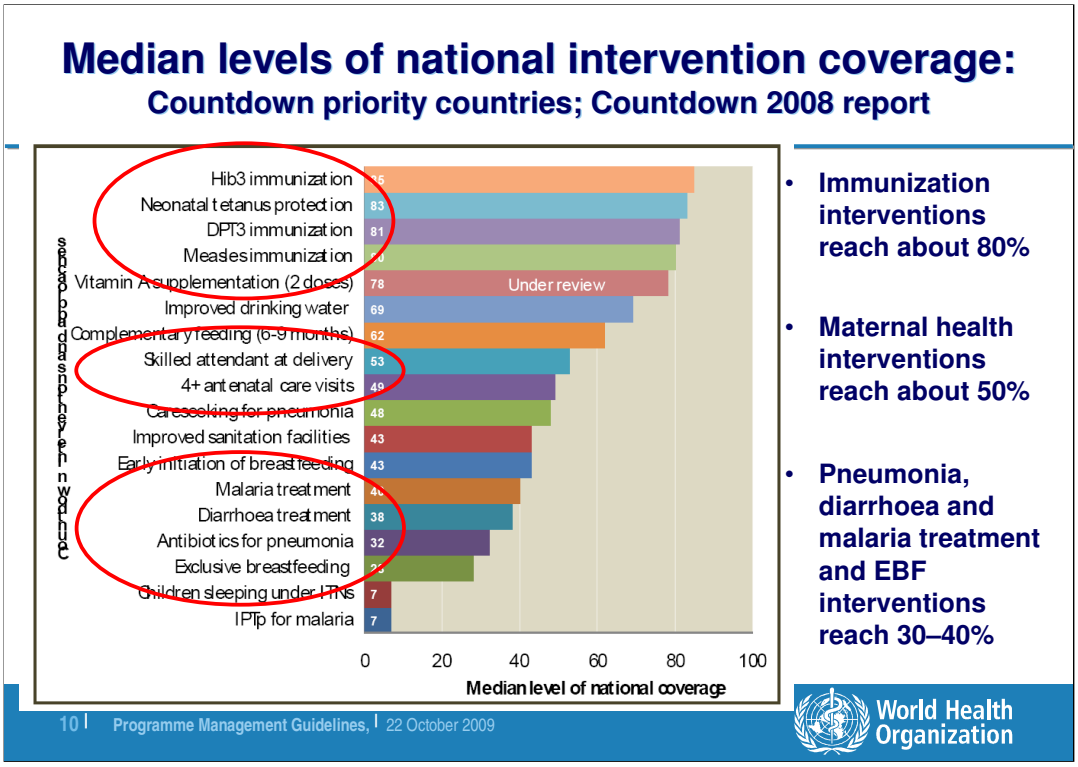
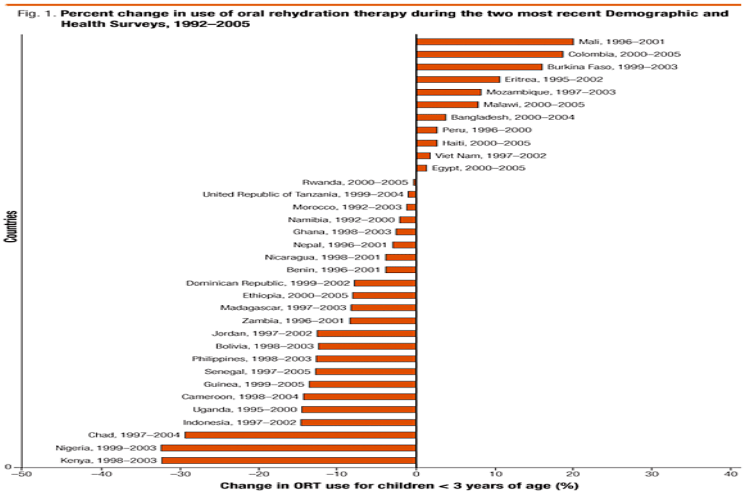


This slide shows the median levels of intervention coverage at the national level from the Countdown countries. The only interventions that reach 80% or more children are immunizations. Only half of all mothers and newborns receive appropriate care during pregnancy and childbirth. It is noteworthy that the interventions with the lowest coverage, reaching only a third of children who need them, are treatment of pneumonia, diarrhoea and malaria, and preventive interventions such as exclusive breastfeeding. (IPTp means intermittent preventive therapy for pregnant women.)

Trends in coverage of ORT



Source: Ram PK et al. *Bull WHO* 2008

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Not only is the current coverage of key child health interventions low, the coverage is not increasing in many countries. This slide shows the change in coverage of ORT for children with diarrhoea in countries that had at least two DHS surveys between 1992 and 2005. While a few countries had an increase in coverage, majority of countries had a reduction in coverage of ORT between the two DHS surveys.

Principles of intervention delivery

- **Coverage:** achieving high coverage of effective interventions is the key to achieving MDG4
- **Equity:** delivery approaches must try to reach the most vulnerable
- **Quality:** interventions should be delivered with quality, "effective" coverage
- **Continuum of care (1):** interventions should span across pregnancy, birth, newborn period, infancy and childhood
- **Continuum of care (2):** relevant interventions must be delivered at home, first-level health facility and referral hospital
- **Packaging and integration:** packaging can create synergies; integration with child at the centre increases quality

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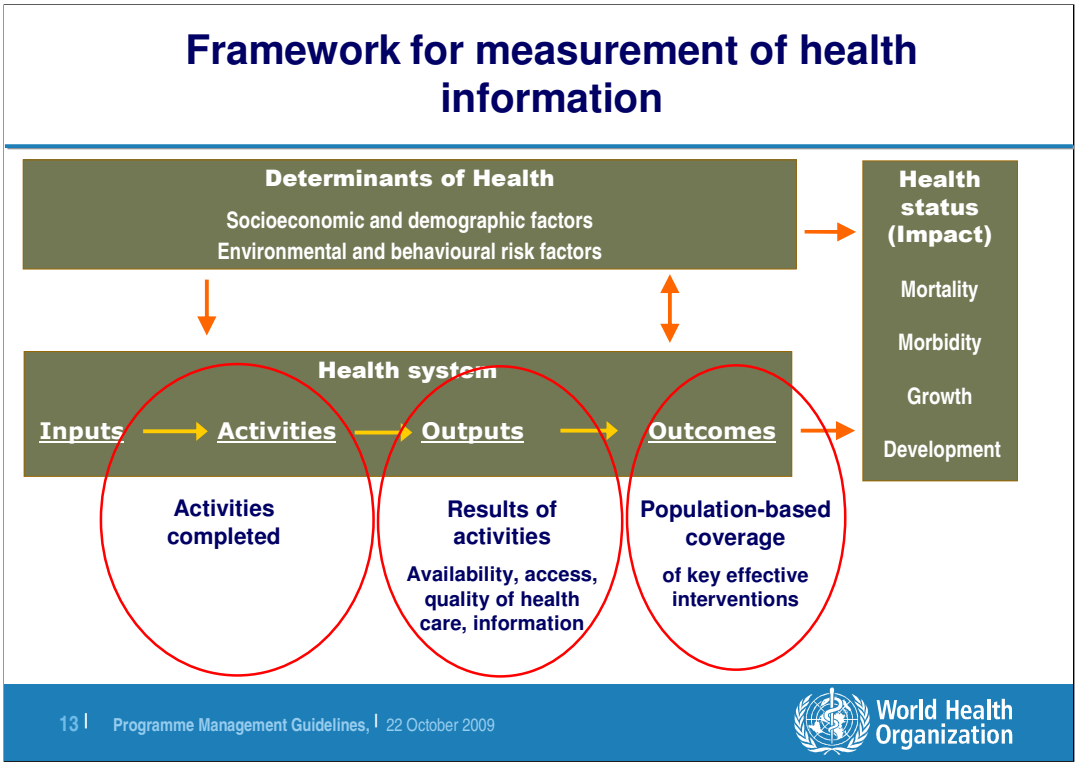
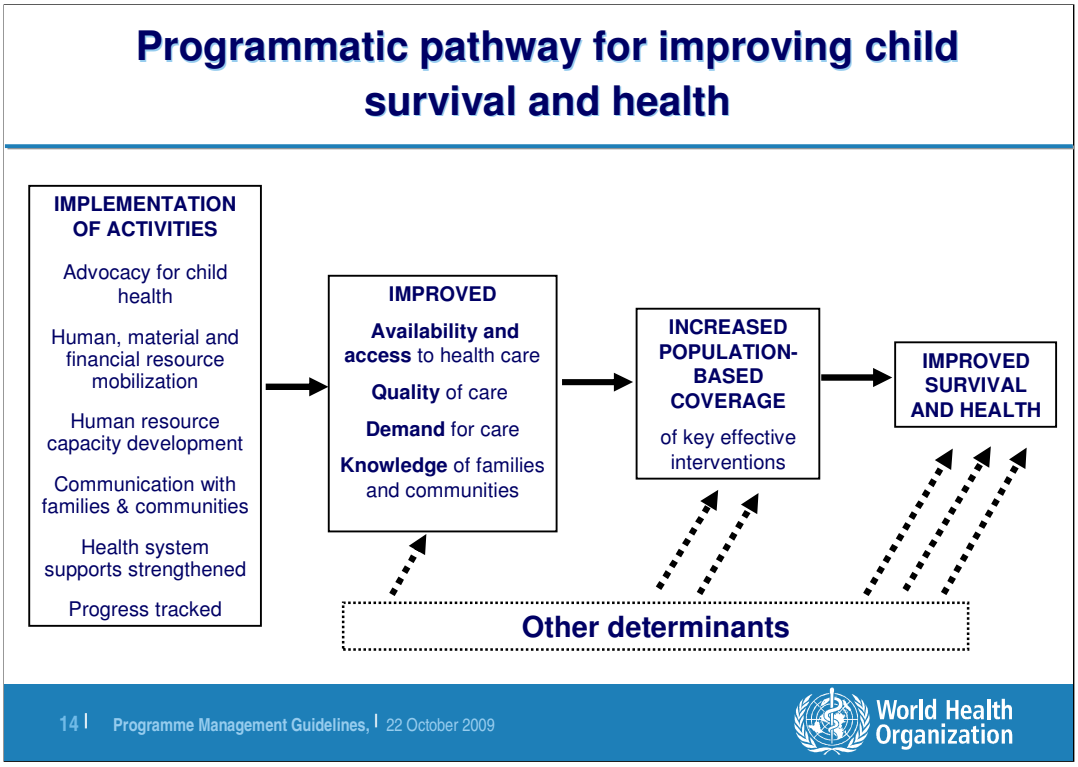
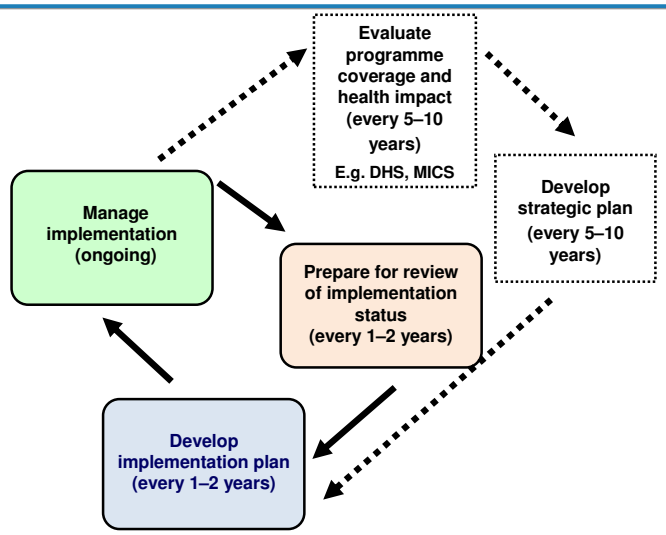


This slide shows the frameworks for measurement of health information and links it to definitions of indicators used in the course. It is envisaged that inputs (human, financial and material resources) would be needed to complete programme activities, which would result in programme outputs (availability of quality health care, increased access and demand for care, information to families and communities), which would result in desired outcomes (mothers and children receiving key interventions), which would contribute to improved health status of the population. In this course, you will learn about three types of indicators – (i) which measure whether the planned activities were completed, (ii) which measure the results of activities, that is, programme outputs, and (iii) which measure population-based coverage of key interventions, that is, programme outcomes.



This slide summarizes the programmatic pathway for improving child survival and health. Implementation of programme activities is expected to improve availability, access, demand and quality of health care. They are also expected to improve knowledge of families and communities about optimal child care practices. The outputs are in turn expected to increase population-based coverage of key, effective interventions. Finally, effective coverage with key interventions is expected to result in improved survival and health. While this is one pathway for improved child health and survival, it is noteworthy that there are several other determinants of child health and survival including socio-economic and education factors.

Planning and management cycles



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This slide shows two inter-linked planning and management cycles. The STRATEGIC PLANNING cycle has a frequency of about 5–10 years and consists of developing a strategic plan, implementing the strategic plan and evaluating the impact. The IMPLEMENTATION PLANNING AND MANAGEMENT cycle fits into the "implementation" step of the strategic planning cycle, has a frequency of 1–2 years and consists of developing an implementation plan, managing implementation and evaluating the results of implementation.

Why are programme management guidelines needed?

- Ensuring high coverage with effective interventions is a must for achieving MDGs
- Child health manager is expected to deliver in a changing and complex environment – decentralization, multiple players, new funding sources: GFATM, PRSP, SWAP
- Being a doctor or a nurse with technical knowledge alone is not enough. Additional skills for advocacy, negotiation, proposal development, presentation, resource mobilization and management are equally important.
- There is more and more recognition of the contributions of all child health-related programmes to the success of child health goals with effective coordination and linkages across the continua of care

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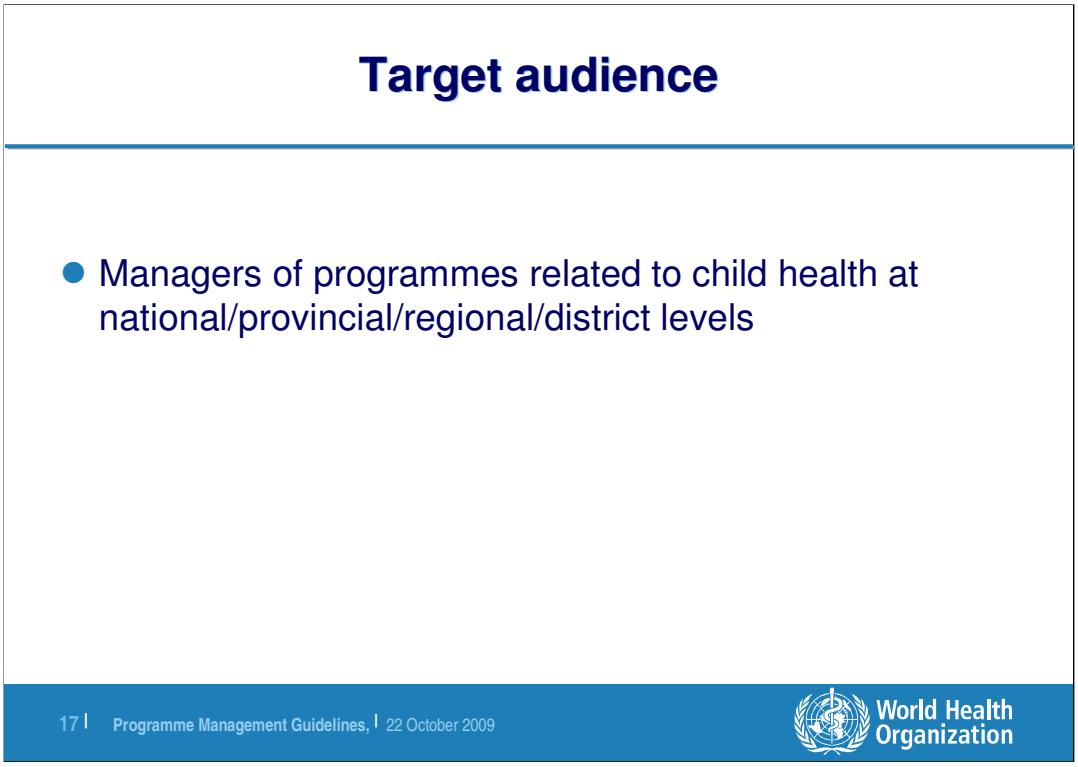

The target audience for this training course is managers of child health-related programmes at the provincial or regional level, district level, and even the national level – managers who plan for implementation, and who manage that implementation.

Objectives

- To improve knowledge and skills for:
  - planning implementation of child health programmes in order to achieve universal coverage of effective interventions
  - management of child health programmes including advocacy, resource mobilization and management

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What will be covered in this course?

- **Developing an implementation plan**
  - Process of implementation planning
  - Understanding and using local data in planning
  - Assessing programme status
  - Deciding priority programme activities
  - Planning to monitor progress
  - Planning for evaluation
  - Writing a workplan and budgeting
- **Skills for managing implementation**
  - Advocacy
  - Mobilizing resources
  - Managing human, material and financial resources
  - Monitoring progress, using data

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What learning methods will be used?

- Short presentations
- Reading & exercises – before or during sessions
- Discussion of local data in small groups – worksheets completed
- Presentation and discussion of small group findings

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Conclusion

- This course will equip the programme manager with the essential knowledge and skills for appropriate planning and management of child health and child health-related programmes to ensure universal coverage of high impact interventions towards the achievement of MDGs.

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