



February 2023

# **CHILD SURVIVAL ACTION**

**A Renewed Call to Action to End Preventable  
Child Deaths**

# Contributing Organizations

The Child Health Task Force coordinated the working group that drafted this document which includes representatives from the Global Financing Facility (GFF), Save the Children, United Nations Children’s Fund (UNICEF), United States Agency for International Development (USAID), and World Health Organization (WHO).

# Acronyms

CSA – Child Survival Action

ENAP – Every Newborn Action Plan

EPMM – Ending Preventable Maternal Mortality

GAPPD – The Global Action Plan for the Prevention and Management of Pneumonia and Diarrhoea

GFF – Global Financing Facility

iCCM – integrated community case management

IMNCI – integrated management of neonatal and childhood illness

JSI – John Snow, Inc.

NMR – neonatal mortality rate

ORS – oral rehydration salts

PHC – primary health care

RMNCAH-N – reproductive, maternal, newborn, child and adolescent health and nutrition

SDGs – Sustainable Development Goals

TOC – theory of change

UNICEF – United Nations Children’s Fund

UN IGME – United Nations Inter-Agency Group for Child Mortality Estimation

USAID – United States Agency for International Development

WASH – water, sanitation and hygiene

WHO – World Health Organization

# Executive Summary

Fifty-four countries need accelerated action to reach the under-five mortality target of the Sustainable Development Goals (SDGs): SDG 3.2.1. The Child Survival Action (CSA) initiative is a renewed call to all partners—national governments, civic and traditional leaders, communities, and regional and global stakeholders—to end preventable child deaths. The initiative urges partners to join hands to address the programmatic and health system challenges that hamper progress in child survival, especially in countries not on track to meet their 2030 targets. Addressing these barriers will require energizing national and subnational leadership, expanding strategic investments in primary health care (PHC) and multi-sectoral actions, mobilizing partnerships across stakeholders, and aligning funding and other initiatives. The initiative identifies opportunities that exist and lays out the steps that partners need to take to reach all children with life-saving interventions.

**A “business as usual” approach to planning and implementing health services for children without considering inequities will result in countries not meeting their SDG commitment to end preventable child deaths.**

In response, the CSA initiative—

1. **Focuses on the 54 countries**, 42 in Africa, that urgently need accelerated efforts to achieve the SDG3 2030 target on child mortality of 25 deaths or fewer per 1000 live births - reaching this target in all countries will avert at least 10 million under-five deaths by 2030.
2. **Reaches the children being left behind** and at risk from leading killers - pneumonia, diarrhea, and malaria - due to malnutrition, lack of access to quality health services including immunization, unsafe water and sanitation, air pollution, conflict and humanitarian disasters, and other key risks to children's health and survival.
3. **Strengthens primary health care** in facilities and communities to more effectively prevent, diagnose, and treat these causes of child death, and to promote good health and nutrition for all children.
4. **Builds effective partnerships** between governments, local partners, civil society, private sector, regional and global organizations, as part of renewed commitment to child survival.
5. **Mobilizes required resources** from domestic and international sources and sectors to deliver on this renewed vision for children's health, nutrition, and survival.

As agreed at the child survival roundtable event, complementary to the World Health Assembly on May 23, 2022:

**There is immediate need for urgent evidence-based action in the 54 targeted countries to tackle the unfinished agenda of child survival, to rally governments and partners for more effective coordination and implementation of policies and investments, both human and financial. Only when children first survive will they be able to thrive and reach their full human potential.**



# About the Child Survival Action Initiative

More than five million children under the age of five died in 2021.<sup>1</sup> Although this number represents a substantial reduction in under-five mortality globally since 1990, it is still unacceptably high. Too many children still face multiple risks to their health and well-being and are often missed by programs and services. In addition, declining investments in primary health care (PHC) are hampering countries' ability to meet children's needs, especially in those countries that are not on track to meeting their 2030 targets.

Fifty-four countries need accelerated action to reach the SDG under-five mortality target of 25 or less deaths per 1,000 live births: (SDG 3.2.1). Deaths in the 1-59 month period represent 54% of overall under-five mortality, with this proportion reaching 70% in some countries (Annex I). The highest rates of child mortality are in sub-Saharan Africa, and the greatest proportions of 1-59 month-old deaths are in West and Central Africa. Inequities in access to services are pervasive in these countries, with many children being left behind.

Ending preventable child deaths requires increased investment in primary health care as the key platform to deliver equitable, high-quality and high-impact interventions for children. If it is well funded and strengthened, PHC will support the delivery of essential services to meet the needs of children and their families. The Astana Conference in 2018 reaffirmed the prioritization of primary health care systems that are people-centered, support multi-sectoral approaches, and cover the life course. At its core, the PHC approach includes:

1. Meeting people's health needs throughout their lives through integrated service delivery.
2. Addressing the broader determinants of health through multi-sectoral policy and action.
3. Empowering individuals, families, and communities to take charge of their own health.

**The Child Survival Action initiative is aligned with the PHC approach to support national, subnational, regional, and global efforts to achieve universal health coverage.**

A focus on metrics is needed to track progress, monitor equity and quality of service provision, and hold all partners accountable for progress. Countries must identify and address leading causes of child mortality by urban, peri-urban, rural, and other population characteristics, as well as coverage of existing programs, to move away from business as usual. This includes identifying the multiple vulnerabilities that many children

**Too many children still die of preventable and treatable causes. Increased investment, better alignment, and strengthened linkages across programs will address the challenges that have hampered high-mortality countries from reducing under-five deaths. The goal of this effort is to end preventable deaths in children, with a focus on children ages 1-59 months. Building on the commitments from EPMM and ENAP, the Child Survival Action initiative is a necessary next step to ensure that no child will survive to infancy only to die of preventable and treatable causes.**

---

<sup>1</sup> United Nations Inter-Agency Group for Child Mortality Estimation (UN IGME) Report, 2022

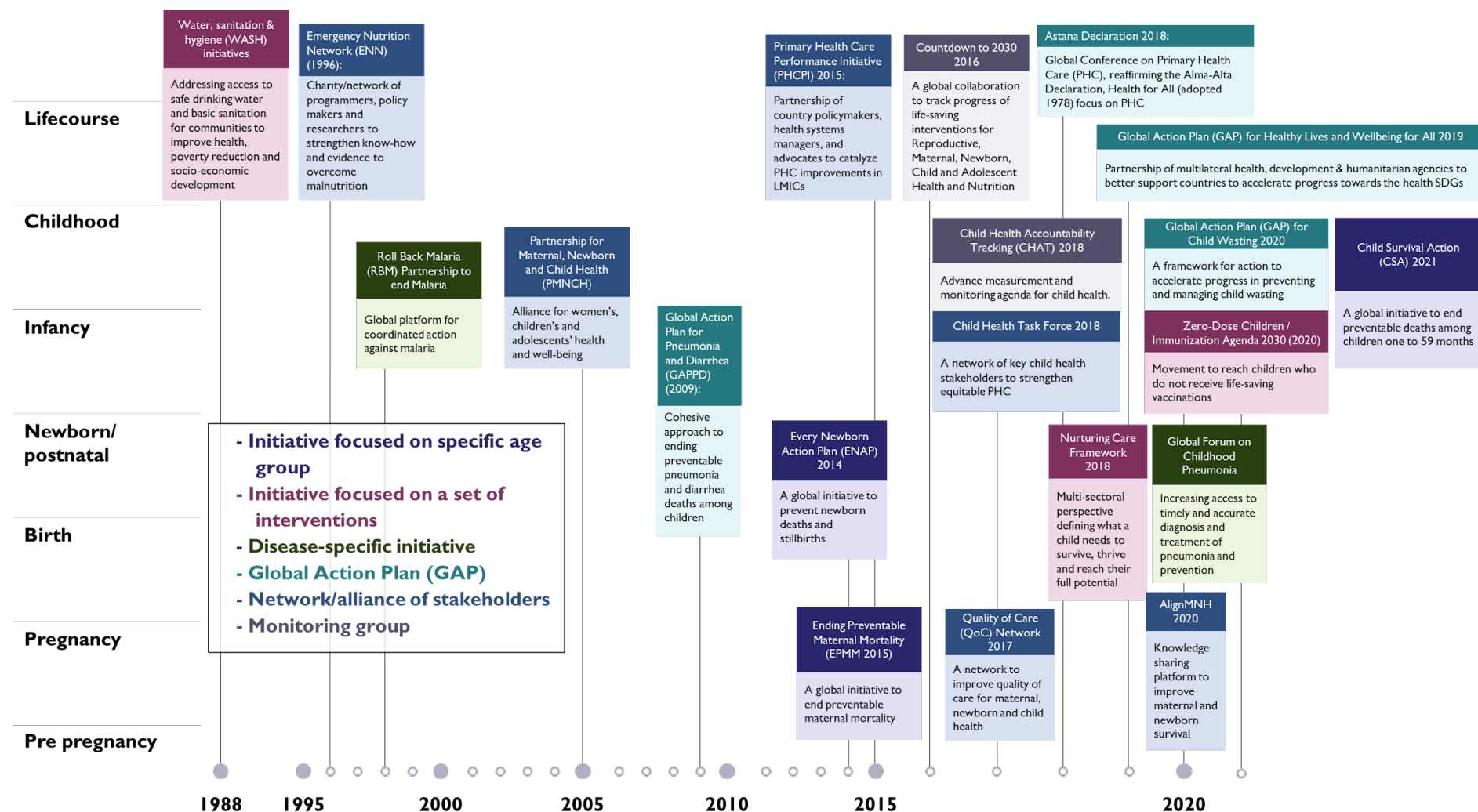
and families face such as being born small or sick, ‘zero-dose’ and underserved through the health sector, experiencing malnutrition, lack of access to safe water, sanitation and clean air, exposure to poverty, experience of stress and mental health problems, and living in a fragile and conflict-affected setting.

The CSA initiative will accelerate progress by sharpening priorities, maximizing existing resources, mobilizing new resources, increasing commitment and leveraging existing partnerships, integrating health programs, and improving coordination across sectors to reduce fragmentation. Progress requires convergence and synergy across partners, which can increase efficiencies, streamline services for families, and reduce the management burden for countries.

This initiative supports SDG 3.2 and the UN Secretary General’s Global Strategy for Women’s, Children’s, and Adolescent’s Health and the WHO/UNICEF: Investing in our future: A comprehensive agenda for the health and wellbeing of children and adolescents. It complements other efforts that promote the continuum of care for maternal, newborn, and child health and those that focus on ending preventable deaths, namely the Ending Preventable Maternal Mortality (EPMM) and the Every Newborn Action Plan (ENAP). The initiative is also aligned with programs focused on reaching the unreached, zero-dose children, which are critical to ending child mortality. All programs that support child health along the continuum of care and life course must converge to achieve greater impact. Figure 1 below is a mapping of partnerships, initiatives and groups that the CSA initiative proposes should collaborate to achieve this goal.

**The Child Survival Action initiative is coordinated by the Child Health Task Force, a network of child health stakeholders and led by WHO, UNICEF, USAID, JSI, GFF, Malawi Ministry of Health, Save the Children, Aga Khan University, Makerere University, and Total Family Health Organisation of Ghana.**

FIGURE I: Initiatives addressing the continuum of care from pre-pregnancy through childhood



# Guiding Principles and Theory of Change

The CSA initiative is a call to partners to address the challenges that have hampered progress in ending preventable child mortality with a focus on high burden countries. It is a collaborative effort aligned with other intra- and inter-sectoral activities that contribute to reducing preventable child deaths.

## Guiding Principles



**Child rights to survive and thrive:** All children have the right to survive and develop their full potential. Within this, every mother and child have the indivisible right to equitable, quality health care.



**Leave no child behind:** Adversities often accumulate at the level of the community, the family, and child. Action must be taken to reach families facing multiple vulnerabilities, including children living in fragile settings, with incomplete or no vaccinations, born preterm or with low birth weight, or who are malnourished. Infants less than 1 year of age carry the greatest burden of preventable mortality.<sup>2</sup>



**Family- and child-centered care:** Children and families should be treated with dignity as a whole person, with all the attendant rights and needs for care and support. Thus, every contact with the PHC platform should be maximized to support the child to survive and thrive, ensuring that comprehensive essential services are delivered to maximize protection (e.g. immunization and identification and referral for undernutrition) and to manage acute conditions that threaten survival and well-being. Families are at the center of providing childcare. They need information, resources, and access to services. Caregivers and children need to have access to a continuum of care, receive quality care and be treated respectfully when receiving health services, have access to effective, positive health communication, and be supported to meet their essential needs.



**Whole-of-government action:** Different sectors need to make investments in the enabling environments that children need for survival. They include health, nutrition, WASH, environmental health, education, child protection, social welfare, and more. Intersectoral policies and structures are needed at national and subnational levels to enable coordinated actions and comprehensive delivery of essential health services.

### Partners

National governments  
Civic and traditional leaders  
Communities  
Civil society organizations  
Multi-lateral organizations  
Bilateral donors  
International non-governmental organizations  
Child Health Task Force  
Academia  
Professional associations  
Private sector  
Countdown to 2030  
Global health initiatives

<sup>2</sup> Children: improving survival and well-being. World Health Organization, 2020. <https://www.who.int/news-room/fact-sheets/detail/children-reducing-mortality#:~:text=In%202019%20an%20estimated%205.2,the%20remaining%202.4%20million%20deaths>



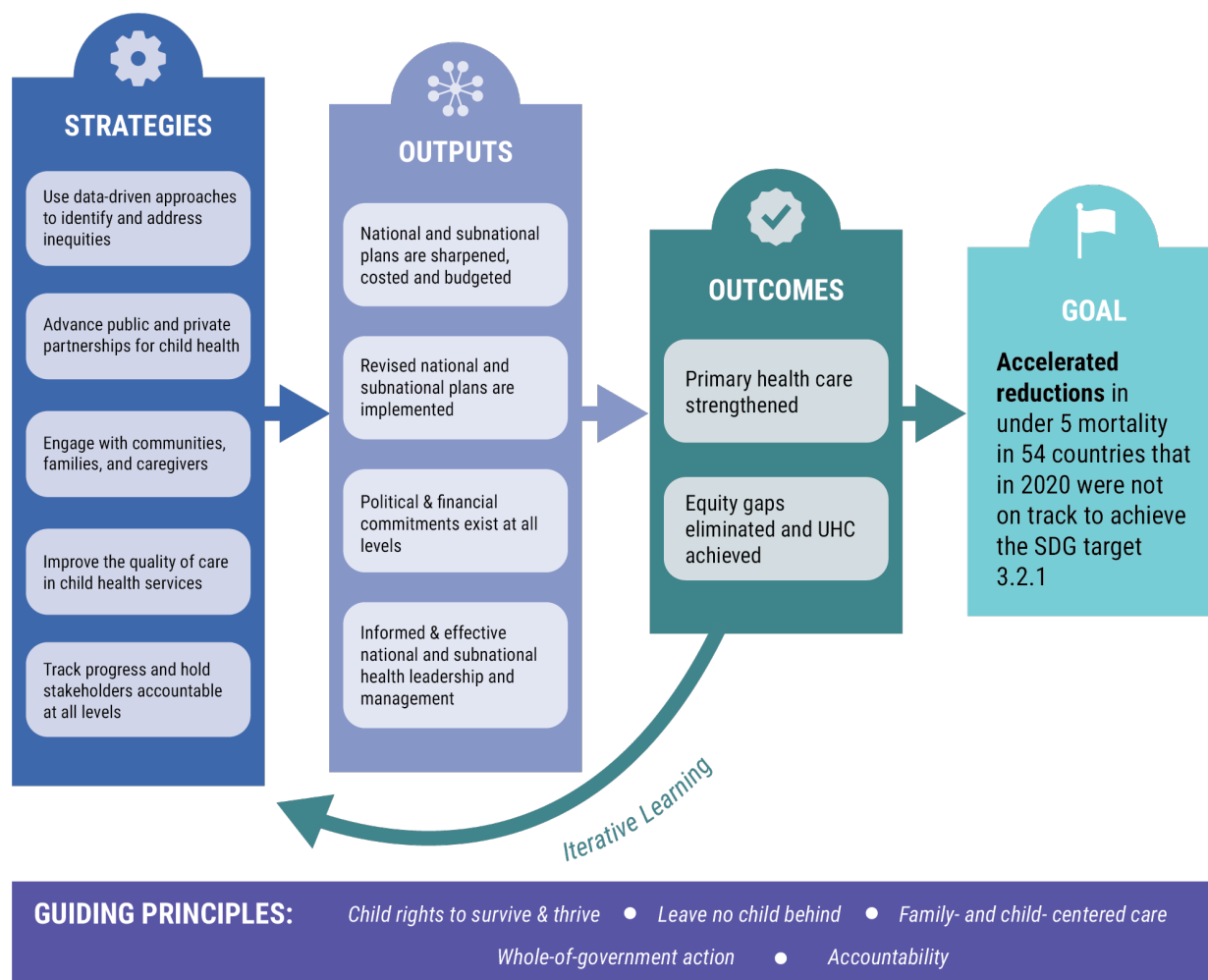


**Accountability:** Priority actions – including the allocation of financial resources, stakeholder engagement, and measures of success – must be driven at all levels by government in consultation with communities. All stakeholders – including governments, civil society, development partners, and the private sector – are accountable for progress to improve child survival.

## Theory of Change

The theory of change for the CSA initiative outlines the strategies, outputs, and outcomes needed to reach the goal and vision of this call to action. It will guide the development of a results framework to track progress towards the desired outcomes and serve as an accountability tool.

FIGURE 2: Theory of change flowchart



## The Vision

The Child Survival Action initiative holds a vision of ending preventable deaths of newborns and children under 5 years of age by 2030, with all countries reducing under-5 mortality to 25 or less deaths per 1,000 live births.<sup>3</sup>

## The Goal

To realize this vision, the CSA initiative aims to accelerate reductions in child mortality to achieve the SDG 3.2 target of an under-5 mortality rate at least as low as 25 per 1,000 live births in all countries. The initiative focuses on the 54 countries,<sup>4</sup> 42 in Africa, that urgently need accelerated efforts to achieve the SDG 2030 target. Meeting the SDG target in the 54 countries would avert 10 million under-5 deaths between 2022 and 2030 and reduce the annual number of under-5 deaths to 2.5 million in 2030.<sup>5</sup> Even more lives could be saved – almost 25 million – if all countries were able to reach an under-5 mortality rate equivalent to the average under-5 mortality rate in high-income countries (5 deaths per 1,000 live births). Under this scenario, there would be just 700,000 under-5 deaths in 2030.<sup>6</sup>

Progress requires a renewed focus to address mortality among children 1-59 months of age alongside attention to reduce newborn mortality. The CSA initiative aligns with and complements the goals and strategic actions of the Every Newborn Action Plan to ensure that all children can survive and thrive in the first five years of life. Both the CSA initiative and Every Newborn Action Plan are closely associated with efforts to reduce maternal mortality, including the Ending Preventable Maternal Mortality (EPMM) initiative.

## The Outcomes

Achieving the Child Survival Action initiative's goal requires realizing two high level outcomes:

1. **Primary health care (PHC) strengthened** to deliver comprehensive, integrated, quality, family-centered child health services, including for the most vulnerable.

Much of the under-5 mortality is preventable through evidence-based interventions that can be delivered at household, community, primary, and secondary level health facilities, including referral care for severely ill children. Primary health care is the foundation for ensuring adequate health care access and achieving

---

<sup>3</sup> SDG Target 3.2: Newborn and child mortality: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality and under-5 mortality.

<https://www.un.org/sustainabledevelopment/health/>

<sup>4</sup> United Nations Inter-agency Group for Child Mortality Estimation (UN IGME). Levels & Trends in Child Mortality: Report 2022, Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation. New York, NY USA: United Nations Children's Fund, 2022. The 54 countries include Afghanistan, Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Cote d'Ivoire, Democratic Republic of the Congo, Djibouti, Dominica, Dominican Republic, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Fiji, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Haiti, Kenya, Kiribati, Lesotho, Liberia, Madagascar, Mali, Mauritania, Mozambique, Myanmar, Namibia, Niger, Nigeria, Pakistan, Papua New Guinea, PDR Laos, Rwanda, Sierra Leone, Somalia, South Sudan, Sudan, Timor-Leste, Togo, Turkmenistan, Uganda, United Republic of Tanzania, Yemen, Zambia, and Zimbabwe.

<sup>5</sup> UN IGME Report, 2022

<sup>6</sup> UN IGME Report, 2022

universal health coverage (UHC). Health systems should be designed and managed to provide comprehensive, integrated, high quality health services in a way that is people-centered and accessible to the entire population, especially those who are most vulnerable.<sup>7</sup>

More specifically, to achieve the child survival targets, PHC should be:

- **Comprehensive:** covering the full spectrum of essential health services for children, including but not limited to those addressing the leading causes of child mortality, namely pneumonia, diarrhea, and malaria, often compounded by malnutrition and preventable by immunization.
  - **Integrated:** delivering inclusive and comprehensive well- and sick-child services through intra-sectoral collaborations across maternal health, newborn and child health, immunization, nutrition, and health promotion. Opportunities for integration should also be pursued through multisectoral collaborations that provide strategic opportunities to improve child survival, such as with WASH, clean air, safe and secure environment, child protection, education, and social welfare.
  - **High quality:** providing primary health care services meeting international and national standards for quality of pediatric care,<sup>8</sup> inclusive of respectful, positive experiences of patients and caregivers.
  - **People-centered:** working with families, caregivers, and children in mutual partnerships to deliver care and meet the essential needs of children and families.
  - **Accessible to all:** identifying and removing the barriers to access and use services that underserved populations face; community health programs and interventions can bring critical services to the hardest-to-reach children.
2. **Equity gaps eliminated and universal coverage achieved** of high-quality promotive and preventive care and treatment of the leading causes of under-5 mortality.

The SDG under-5 mortality target cannot be achieved without eliminating equity gaps and achieving universal access to and coverage of high-quality promotive, preventive, and curative interventions addressing the leading causes of under-5 mortality, including but not limited to pneumonia, diarrhea, and malaria.<sup>9</sup> Infancy is the period with the greatest risk of mortality due to these causes and, therefore, must get special attention. Strategic efforts, including data-driven approaches, must be made to identify and reach the most vulnerable. Vulnerable subpopulations include, but are not limited to, children who have not received a single vaccine (zero-dose) or the full complement of childhood vaccines (under-immunized), premature and low birthweight babies, and suffering from moderate or severe acute malnutrition (wasting or undernourished). Additional contextual vulnerabilities include living in fragile settings, being part of socially marginalized groups, and geographies. Strong partnerships across sectors and between communities, civil society, governments, and other partners are critical to address risk factors and deliver the essential services to the hardest-to-reach children and communities.

---

<sup>7</sup> Vulnerable populations are groups and communities at a higher risk for poor health as a result of the barriers they experience to social, economic, political and environmental resources, as well as limitations due to illness or disability. <https://nccdh.ca/glossary/entry/vulnerable-populations>

<sup>8</sup> Standards for improving the quality of care for children and young adolescents in health facilities (Policy Brief). WHO, 2019. [https://cdn.who.int/media/docs/default-source/mca-documents/child/standards-for-improving-the-quality-of-care-for-children-and-young-adolescents-in-health-facilities--policy-brief.pdf?sfvrsn=1e568644\\_1](https://cdn.who.int/media/docs/default-source/mca-documents/child/standards-for-improving-the-quality-of-care-for-children-and-young-adolescents-in-health-facilities--policy-brief.pdf?sfvrsn=1e568644_1)

<sup>9</sup> UN IGME Report, 2022

## The Outputs

Sharpened, prioritized actions for child survival should contribute to four main outputs:

1. Existing national and subnational **plans are sharpened, costed, and budgeted** to leverage and improve child survival investments and outcomes.

Most countries have national plans for reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH-N). However, they may be insufficiently prioritized, underfunded, not explicitly address risk factors contributing to illness, and encounter barriers hampering effective delivery of quality services. Critical considerations to improve child survival include addressing inequities, quality of care, and robust linkages between relevant health programs (e.g., IMCI, immunization, malaria control) and other sectors that contribute to child health (e.g., nutrition, WASH, environment). The plans should be balanced to support a continuum of care, from pregnancy through childhood, in communities and across health service platforms, and developed under government leadership with the engagement of affected communities, civil society, and other stakeholders.

A “sharpened” plan sets priorities against realistic estimates of available resources; it leverages human and financial resources of all sectors to create an “investment case” for RMNCAH-N. In some countries, the Global Financing Facility (GFF) supports countries in developing such sharpened plans and RMNCAH-N investment cases. National and subnational budget planning, including domestic and external resources, should contribute to and align with the investment cases to ensure adequate resources are efficiently and effectively mobilized for child survival, as well as thrive and transform agendas. Sharpening plans may require updates to existing plans in health and other sectors, with alignment between the RMNCAH-N plans and national immunization strategies (NIS) and multisectoral nutrition strategies.

Plans should be based on existing data and reflect country-specific contexts—including the mix of providers, burden of child health conditions, individual risk factors and vulnerabilities, and contextual changes, including environment and climate. Plans must consider the platforms and partners available to respond to child survival needs, and should harmonize measurement and monitoring frameworks for child health at all levels. Plans strengthening primary care contribute to achieving universal health coverage.

2. **Revised sharpened national and subnational plans are implemented with** high quality and with a focus on reaching the most vulnerable families and children.

All partners agree that the country-led prioritization of systems and interventions to accelerate child survival described in sharpened plans should drive all investments and reporting requirements. Existing country platforms for effective alignment (e.g., Technical Working Groups) may need strengthening to ensure effective leadership, management, and coordination.

National and subnational plans should be implemented across the continuum of care, from households and communities to primary level health facilities, with robust referral mechanisms to secondary and tertiary hospitals. Where possible and appropriate, the implementation should build on the existing platforms and architectures at the community level to provide services, promote behaviors, and strengthen accountability and ownership. Service delivery platforms may need to be reinforced with adequate staffing, supplies, and equipment, along with improved linkages and referral mechanisms. Implementation will engage multiple



partners across multiple sectors to positively influence behaviors, practices, and quality service delivery in households, communities, and health facilities.

3. **Political and financial commitments exist** at all levels (subnational, national, and international) to support the delivery of primary health care to all children under-5.

National governments should support local authorities with the political, financial, and human resources required to adapt and implement sharpened plans to achieve child survival objectives. Global partners, including donors, should be ready to support the implementation of country plans, including investing in critical health system functions required for child health service delivery.

Increased financial resources, domestic and external, aligned with the sharpened plans that support child survival also contribute to commitments to universal health coverage. Resource mobilization may include pooled funding to support critical health system functions required for child health service delivery.

4. Informed and effective **national and subnational health leadership and management** support multisectoral, multi-stakeholder actions.

Committed, informed, and effective health leadership and management must be in place at national and subnational levels to support the implementation of sharpened child survival plans. Leadership and management provide essential stewardship of national and subnational strategies, mobilize and coordinate resources and partners, ensure the robust implementation of prioritized efforts, and are accountable to governments and communities for achieving the outcomes.

Where necessary, national and subnational leadership and management in public and private health sectors should be strengthened to have the capacities, skills, and authority to allocate sufficient resources and review progress towards child health objectives. Health leadership and management at all health system levels (e.g., national, regional, district, facility, community) must be well trained in the essential competencies and provided with adequate resources to effectively manage health programs. Opportunities for continuous professional development should complement the initial training of health leaders and managers.

Leaders and managers at all levels must have the human, financial, and technical resources to effectively plan, implement, monitor, and evaluate their programs. Examples of these resources include but may not be limited to management and technical staffing, funding, health care infrastructure and essential supplies, routine data, and more.

## The Strategies

Outputs are contingent on implementing five strategies, or pillars, that are the foundation of the CSA initiative. These pillars represent the pivot from business as usual to accelerating progress in averting preventable mortality for all children, focusing on those left behind.

1. **Use data-driven approaches** to identify inequities in outcomes and reach the most vulnerable families and children.

Some children are more vulnerable to early mortality than others. National plans should incorporate subnational data analyses to identify the most vulnerable populations, the strategies to reach those

populations, and monitor progress on delivering accessible, quality interventions most likely to impact child mortality at the household, community, or health facility levels. Plans will need to reflect dynamic, local contextual realities, including environmental changes, and retain the flexibility to use programmatic evidence and data to make adaptations where necessary to improve outcomes.

Data-driven approaches play a critical role in routine program monitoring, evidence-based decision-making, and multi-stakeholder accountability mechanisms. A single monitoring framework should align with the sharpened plans and reflect the approaches and strategies identified to reach defined vulnerable groups. It should build as much as possible on existing data systems, with a focus on improving data availability, quality, and use at all levels.

Regular collection and use of quality granular data are essential to understanding the context-specific challenges and opportunities for children's survival, healthy growth, and development. Analyses may include cause of death, clinical and contextual risk factors, and coverage and quality of evidence-based preventive, and curative behaviors, practices, and services. They should be stratified by target populations, age, subnational geographies, rural/urban environments, gender, and other contextual drivers of inequitable access to quality care. Special studies, including qualitative or ethnographic methods, may be required to understand better and address risk factors that are difficult to address.

2. **Advance public and private partnerships** for child health within and between health and other sectors.

Integrated, multisectoral, evidence-based approaches aligned with sharpened plans will support children's survival, healthy growth, and development. Delivering inclusive, comprehensive, quality well- and sick-child services requires innovative partnerships within the public and private health sectors across maternal health, newborn and child health, immunization, nutrition, and health promotion. Collaborations with multisectoral public and private sector partners, such as with WASH, environmental conservation, child protection, education, and social welfare, also provide strategic opportunities to reach vulnerable children.

Partnerships must be built, strengthened, and maintained between governments, local partners, civil society, the private sector, regional and global agencies, and donors to deliver strengthened, more responsive health promotive and treatment effectively. Partnerships should look for opportunities to combine strategies, integrate approaches, and serve as new points of entry to reach at-risk children under-5 with health promotion, prevention, and treatment interventions.

Communities often are targeted by multiple partners. Strengthened and committed leadership must coordinate and align resources and partner support (domestic and international, public and private) to maximize efficiencies and equity. Strong partnerships between local authorities and community leaders are instrumental in defining what support should be provided and how it is delivered.

3. **Engage with communities, families, and caregivers** to improve household health-related prevention, promotion, and care-seeking practices for children under 5.

Communities, families, and caregivers should be engaged not only in seeking care but also from the beginning in decisions regarding the tailoring of health systems and health care delivery. Community engagement helps ensure that care is centered around the needs of the child and its family so that it is inclusive, accessible, supportive, affordable, accountable, and fully meets their needs. The benefits of engaging people and

communities are particularly pronounced with marginalized and vulnerable groups. Identifying the groups most vulnerable to elevated child mortality and involving them in the planning and delivery of services can improve the health system's responsiveness and enhance use by marginalized families, which will be critical to achieving equitable health outcomes for children under 5.

People's voices and ideas are necessary to formulate, plan, and implement plans that respond to needs and preferences. Empowered families actively contribute to the organization, regulation, and delivery of public or private health services in their communities.<sup>10</sup> Active engagement through community groups and social accountability mechanisms in the planning and implementation of sharpened plans allows services to respond to the social and cultural circumstances of the people, which in turn increases access, effectiveness, responsiveness, and, ultimately, outcomes.<sup>11,12</sup>

Individuals and caregivers play a central role in managing their own health and well-being and in providing informal care to their children. Self-care and caregiving as integral components of PHC efforts to improve health and well-being. Individuals, families, and communities need access to the knowledge, skills, and resources required to meet their specific needs and sociocultural circumstances. Community health programs and interventions can bring critical services to the hardest-to-reach children. Sharpened plans and their implementation should incorporate these approaches using innovative partnerships and integration opportunities to address child survival.

#### 4. **Improve the quality of care**, with attention to both provision and experience of care.

Children and families need access to high-quality health care services if the SDG child mortality targets are to be achieved. International quality of care standards<sup>13</sup> should inform the sharpening of national and subnational plans to ensure that the care provided to all children is evidence-based, safe, effective, timely, efficient, equitable, and appropriate for their age and stage of development.

Quality services include initiation and completion of immunization schedules; proper identification, management, and follow-up of cases of malnutrition; timely detection, case management, referral, and follow-up of childhood illnesses; timely and accessible treatment of injuries. Quality services also should integrate growth monitoring with child survival strategies and promote behaviors and practices that families can engage in, such as breastfeeding during and after illness episodes.

Quality standards also require that care be people-centered, nurturing and compassionate, supportive, affordable, convenient, and free from discrimination and judgment. The resulting positive experience of care not only upholds the dignity and human rights of patients, caretakers, and families but is also a critical determining factor in reinforcing positive adherence to advice and treatment, future care-seeking behaviors,

---

<sup>10</sup> A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. WHO and UNICEF, 2018 (WHO/HIS/SDS/2018.15).

<sup>11</sup> Cyril S, Smith BJ, Possamai-Inesedy A, Renzaho AMN. *Exploring the role of community engagement in improving the health of disadvantaged populations: a systematic review*. Glob Health Action. 2015;8. doi:10.3402/gha.v8.29842

<sup>12</sup> Rosato M, Laverack G, Grabman LH et al. *Community participation: lessons for maternal, newborn, and child health*. Lancet. 2008;372(9642):962-971.

<sup>13</sup> Standards for improving the quality of care for children and young adolescents in health facilities (Policy Brief). WHO, 2019. <https://www.who.int/publications/i/item/9789241565554>

and ultimately, improved health outcomes for children under five. Sharpened plans must be implemented with data-driven monitoring of the quality of care for continuous improvement.

5. **Track progress and hold stakeholders accountable** at all levels for increased commitment and improved responsiveness to the health needs of children under-5.

Progress towards the SDGs needs to be monitored closely to make strategic, timely adjustments where needed. Locally available data from multiple sources, including health information systems, health facility assessments, population-level surveys, and periodic in-depth studies, should be leveraged and stratified to identify populations in need of special attention. Health leadership and management skills and capacities should be strengthened to capture, analyze, and use data for decision-making.

Tracking progress requires developing, deploying, and implementing a monitoring and accountability framework. The CSA initiative's accountability framework will provide milestones and proposed indicators to facilitate the tracking of progress. National and subnational stakeholders will have to adapt the proposed framework to their local situations and contexts, strengthen capacities to review and interpret data, and deploy the framework to hold stakeholders accountable at multiple levels.

All stakeholders are accountable for progress to improve child survival. Priority actions – including allocation of financial resources, stakeholder engagement, and measures of success – must be driven by government at all levels and in consultation with communities. All stakeholders are mutually accountable for fulfilling their roles and responsibilities to achieving child mortality targets. This means that all stakeholders have an active role in accountability mechanisms and that each entity should hold each other accountable. These stakeholders include, but may not be limited to, patients, families, community members, civil society, national governments, subnational managers, donors, global stakeholders, academic and research institutions, and the private sector.

# Country Roundtable

On May 23, 2022, linked to the 75<sup>th</sup> World Health Assembly in Geneva, the Sierra Leone and Tanzania Ministries of Health and partners co-hosted a roundtable to discuss actions for child survival and renewed commitment from national and global leadership. The key takeaways from the roundtable are summarized below.<sup>14</sup>

## Accelerated action for child survival towards 2030 is urgently needed

The data are clear – too many children die because of common but preventable illnesses. Inequities are pronounced not only across countries but often times within countries. These inequities are further being exacerbated by conflict, climate change, food insecurity and most recently COVID-19.

Urgent action is needed to ensure that children survive early childhood, a critical first step in ensuring they can fully thrive and reach their full development potential. It is also crucial to specifically address sub-national inequities in mortality outcomes, access to and utilization of high-quality health services in facilities and communities, and an enabling environment to promote positive child health outcomes and multi-sectoral action, including good nutrition, WASH services, educational opportunities for women and girls.

## We know what works

While there is no one-size-fits-all approach, there are many evidence-based and affordable health care interventions, including immunization, better nutrition, quality diagnosis and treatment that have proven to give children a good start in life. However, there is a knowledge-to-policy gap, and fragmentation in the way government and global public health partners facilitate implementation. There is therefore a need for:

- strong government leadership and accountability, and multi-sectoral responses aligned with national strategies that bring together multi-stakeholders from health (including immunization), nutrition, WASH and protection together;
- people-centred, equitable, and quality primary health care delivered in communities and facilities by a capacitated, skilled, remunerated and motivated health workforce (including fully integrated community health workers) with reliable access to essential supplies, and supportive leadership and management;
- an approach that combines not only domestic financing, external pooled investments and innovative approaches, but also a commitment to making better use of existing resources;
- engaging communities in the design and implementation of multi-sectoral responses;
- strengthening and utilizing country data systems on a continuous basis to focus on vulnerable children is critical to ensure accountability at all levels for change; and
- an equity-sensitive approach that builds upon the actions to reach zero-dose and under-immunized children, as well as those with acute malnutrition and wasting, to reduce the risk of mortality in highly vulnerable children.

---

<sup>14</sup> Child Survival Action: A roundtable discussion for accelerated progress towards 2030 Event Recap. Child Health Task Force, 2022. [https://www.childhealthtaskforce.org/sites/default/files/2022-06/FINAL\\_Event%20recap\\_WHA%20Child%20survival%20action.pdf](https://www.childhealthtaskforce.org/sites/default/files/2022-06/FINAL_Event%20recap_WHA%20Child%20survival%20action.pdf)



# Partnering with Countries and Implementation

Countries are at the center of action. Inherent to the approach is alignment of existing plans and programs, adaptation to the local context, intra- and inter-sectoral coordination and collaboration to leverage resources, expertise and lessons learned, documentation and iterative learning, and continuous monitoring and quality improvement, toward reaching national and sub-national targets and goals.

The initiative focuses on countries in the African region that need accelerated actions to reach the SDG target for under-five mortality, particularly those with high mortality in the 1-59 month period. As of February 2023, the initiative is partnering with Nigeria, Sierra Leone, South Sudan, and Tanzania. Moving forward, the CSA initiative is prepared to partner with any country in which the government expresses interest and commitment to reducing under-five mortality. The CSA initiative seeks to leverage opportunities in countries such as the revision of child health or RMNCAH-N strategies, investment cases, budget renewals, and other government-led and partner-supported initiatives.

**At the country level:** In each country that elects to participate, national-level leadership will ensure child survival is integrated into their child health or RMNCAH-N plan and health sector strategic plan, in collaboration with national- and subnational-level technical and civic leaders. Rather than a new or parallel process, all actions will build on and amplify existing child health plans and operational processes to call the attention of all stakeholders to the continuing high levels of preventable mortality and agreeing on a set of actions to accelerate progress towards meeting the 2030 target. Thus, specific actions will be determined by this national-level process. Global organizations that are part of the initiative will be key actors through existing national and subnational health steering and/or technical working groups to ensure involvement of stakeholders at each level of the system. The key actions, including advocacy and joint tracking of progress, will happen at the national and subnational level.

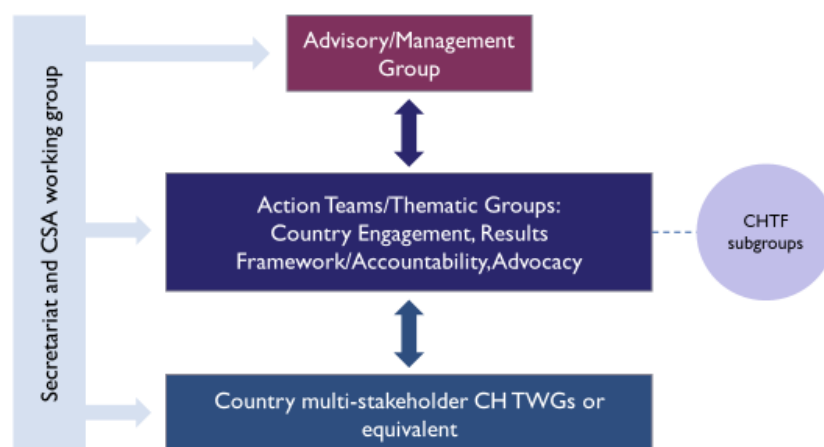
**At the regional level:** Subject to consensus, participating countries leverage existing regional bodies to support cross-country actions and engender learning that can be applied across all 54 countries.

**At the global level:** Building on the consultations that formed the CSA initiative, partners that join this initiative will select an initial set of countries from the 54 based on convergence of global health initiatives, national programs, and more importantly, the interest of national leadership to be part of the initiative. In addition, these partners will develop an advocacy strategy to target specific audiences for resource mobilization and awareness about the unfinished agenda of high preventable deaths in infancy and early childhood.

## Governance Structure

The child survival working group proposed a governance structure to support the implementation of the initiative that exemplifies/reinforces collaboration and alignment at different levels.

FIGURE 3: Governance structure diagram



**Advisory Group mandate:** To offer strategic inputs into the CSA initiative’s vision and agenda and look for opportunities to make it a reality. To endorse the vision and agenda, leverage high-level entry points, relationships, and opportunities for funding, and shape the strategic direction of the initiative. The members of the group will show commitment to championing child survival within their respective organizations and on the global stage.

### Action Teams

1. **Country Engagement mandate:** To develop a phased approach for partnering with countries, manage relationship with regional bodies, country governments and other in-country stakeholders. To strengthen technical working groups and support “forensic” data analyses, costed plans to inform advocacy and clearly defined priorities for child survival.
2. **Advocacy mandate:** To lead/provide direction on implementing the CSA advocacy strategy, associated advocacy materials, and efforts to raise awareness of the need to accelerate actions for child survival at all levels (sub-national, national, regional and global). To galvanize leadership and commitment of key partners at all levels. To target different audiences with one voice, in-line with other complementary efforts.
3. **Results Framework mandate:** To develop, in consultation with key stakeholders and countries, resources for the CSA initiative that allow measurement of progress, including a results framework for accountability. To support countries to track key tracer indicators and milestones for child survival within existing monitoring and evaluation systems.

# Annex I: Evidence to Support the Child Survival Action Initiative

## Unmet Promises of Child Survival

Despite improved child survival globally, 54 countries need accelerated action to achieve SDG target 3.2 by 2030.<sup>15</sup> Some countries have stagnated, and others have reversed progress due to multiple factors including under-investments in health systems, the health workforce, and community health services. Conflict, displacement, and humanitarian disasters have also put children in many countries at risk of dying. Further, the COVID-19 pandemic has led to disruptions in preventive and curative care and economic impacts, with potential to increase numbers of under-immunized and under-treated children, and elevated levels of severe malnutrition in children.

## Sustainable Development Goal 3.2

**By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.**

**Deaths in the 1-59 month period accounted for 2.7 million of 2021's under-five deaths.** Mortality in this age group accounts for a substantial proportion of all under-five deaths in the 54 countries needing accelerated action, greater than 60% in some countries. To accelerate progress toward the SDG 3.2 target, investments must be made to achieve mortality reductions in both the newborn and the 1-59 month periods.

**Global and country investment in newborn and maternal health has enabled substantial progress in reducing related mortality and improving health outcomes across the MNCAH continuum of care.**

However, the lack of attention to children 1-59 months has left a gap that compromises the gains in the earlier life stages and can generate harmful impacts later in life. To invest in a newborn's survival only for that baby to die of pneumonia at 11 or 24 months is an avoidable tragedy. Families seek care for newborns and children in the same facilities, from the same community- and facility-based health providers. In addition, the health and well-being of mothers is fundamental to the health and well-being of newborns, infants, and young children. Investing in a comprehensive agenda is key to ensuring that every child grows up to become a

---

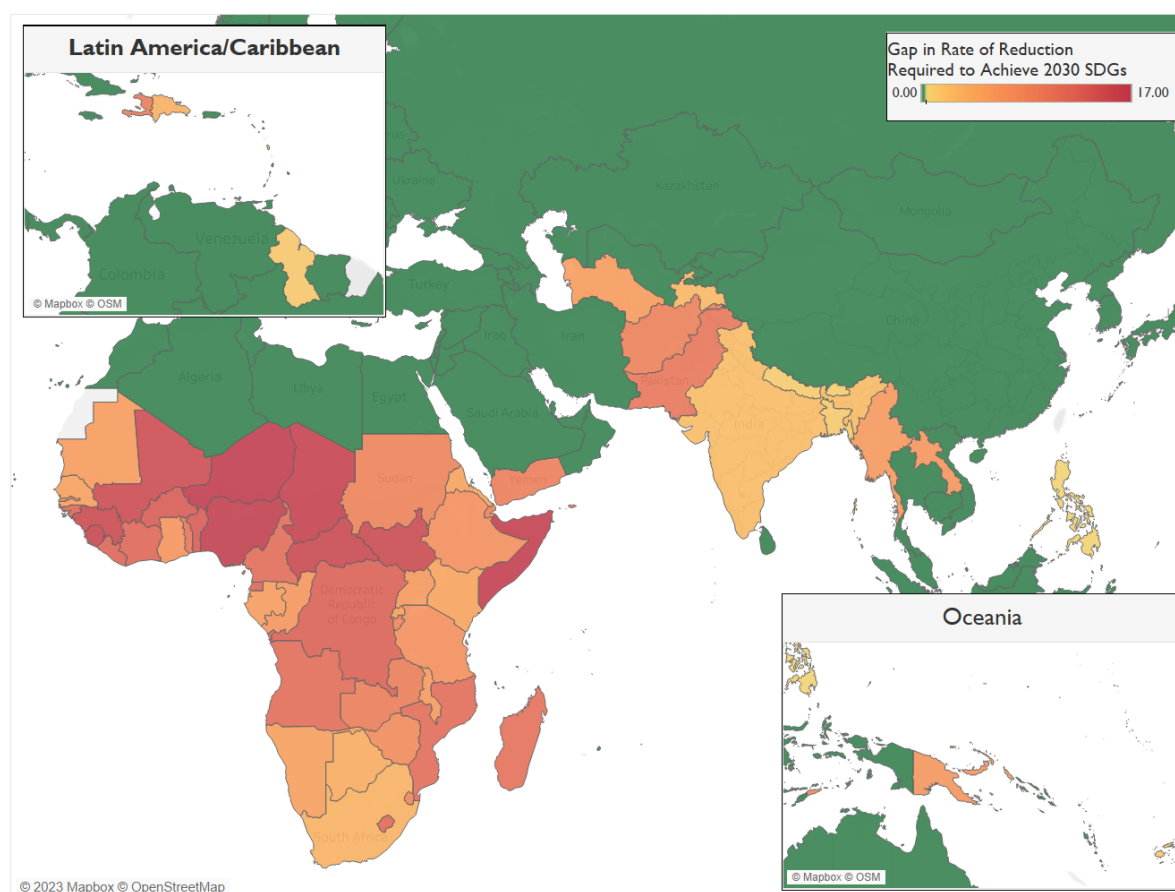
<sup>15</sup> UN IGME Report, 2022

healthy and thriving adolescent, and an adult who can become an agent of change in their community and productive member of society.

**A “business as usual” approach to planning and implementing preventive and curative health services for children, and a lack of strategic investments in PHC, will result in stagnation of progress (Figure 6).**

In the 54 countries needing accelerated action, there is a big gap between the historical average annual rate of mortality reduction (2010-2021) and the rate required to achieve the 2030 target, as shown in Figure 4 below.

**FIGURE 4: Countries needing accelerated action to achieve SDG target 3.2**



## Burden of 1-59 Month Mortality Rate and Projected Progress

The highest rates of preventable child mortality are in sub-Saharan Africa, where 7 countries (see Figures 5 and 6 below) continue to have 1-59 month mortality rates exceeding 50 deaths per 1,000 live births in 2021. While many countries have decreased the 1-59 month mortality rate compared to the neonatal mortality rate

(NMR), particularly in the Asia region, 1-59 month mortality still surpasses that of NMR across the African region. In twelve countries, 1-59 month mortality accounts for 60% or more of all under-five mortality; ten of these countries are in West and Central Africa.

Given the need to accelerate under-five mortality reductions in the 54 countries needing accelerated action and the substantial burden of mortality in the 1-59 month period, global and country partners need to align and expand strategic investments in child survival in infancy and early childhood.

**FIGURE 5: Percent of under-five deaths (neonatal versus 1-59 months) for countries needing accelerated action to achieve SDG target 3.2, 2021**

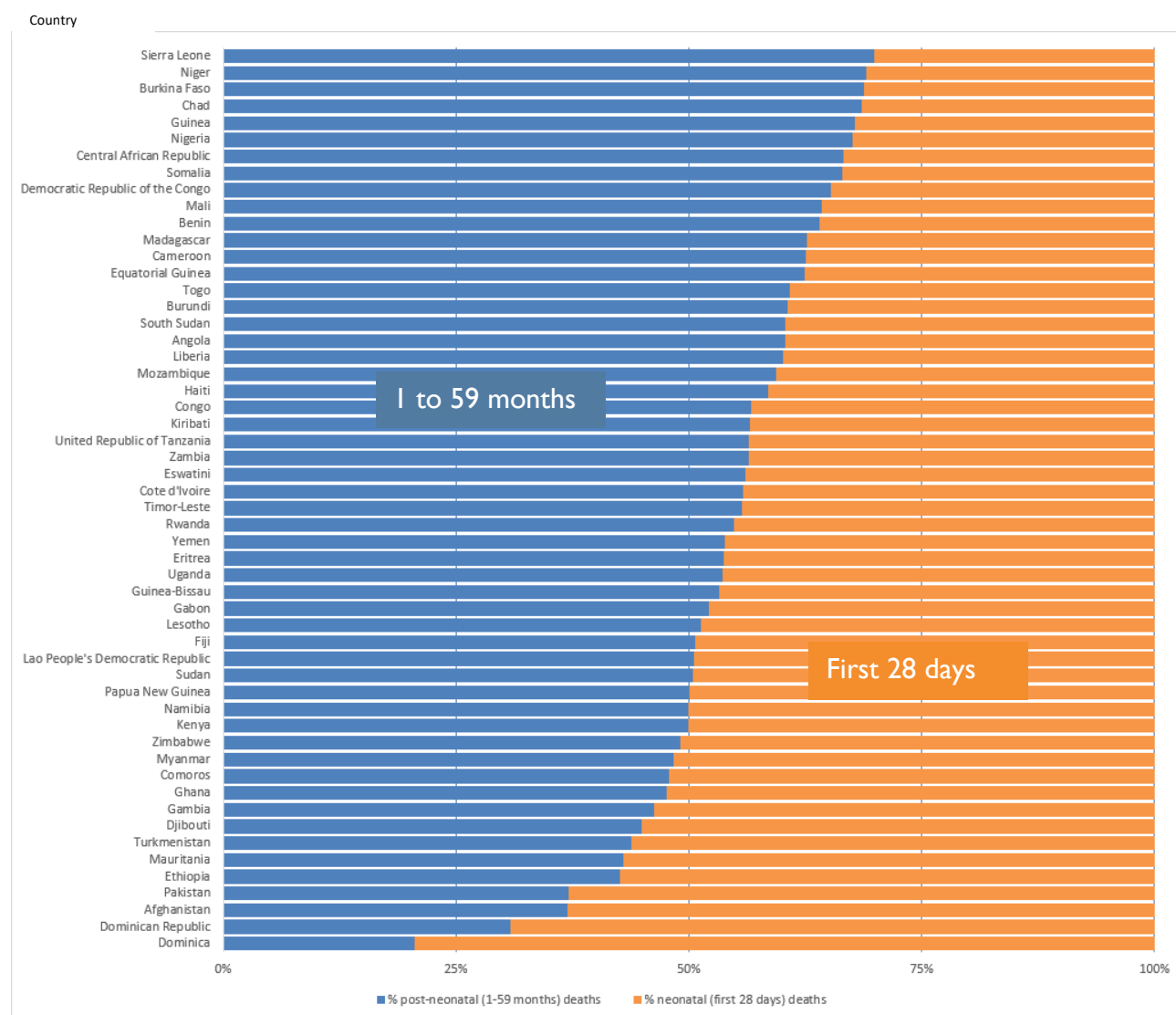
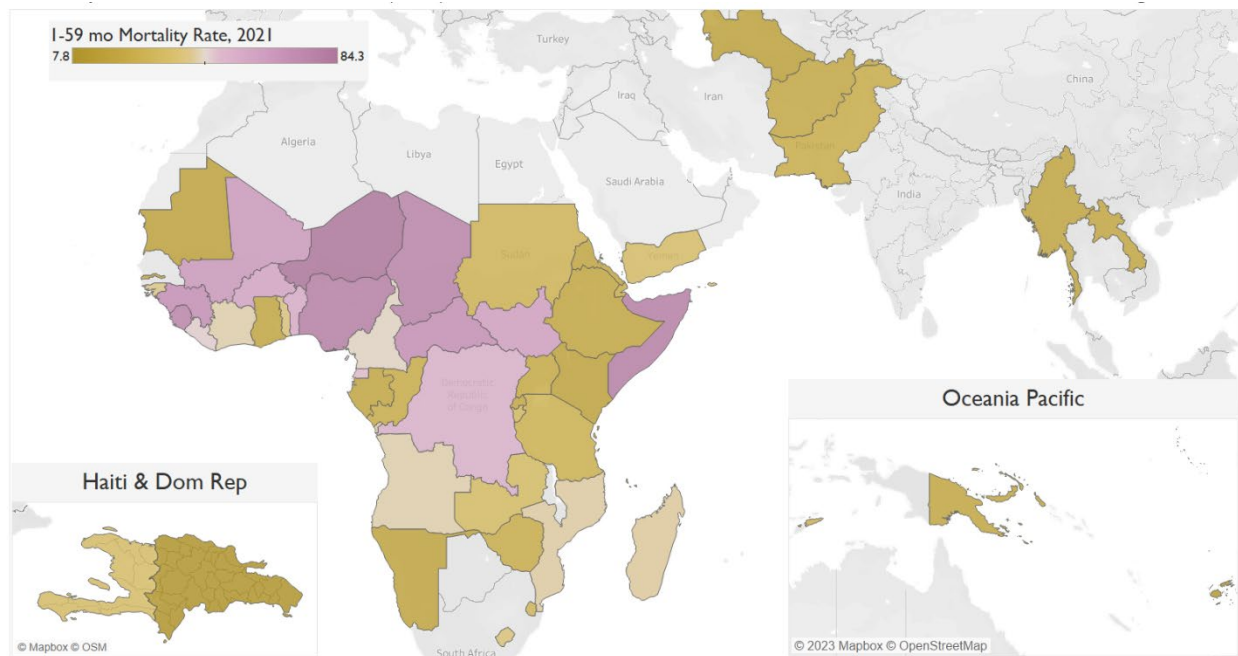




FIGURE 6: One to 59 month mortality rate, 2021



## Understanding and Addressing Subnational Inequities is Key to Ending Preventable Under-five Mortality

Beyond understanding where a country stands in terms of its levels of under-five mortality, segmented into neonatal and 1-59 month mortality, it is critical for countries and partners to acknowledge subnational inequities in child survival. There are multiple levels of inequity, with potential overlapping determinants of equitable access to high-quality services for children.

A granular understanding of the variation in leading causes of child mortality by urban, peri-urban, rural, and other population characteristics, as well as coverage of existing programs, will be necessary to move away from business as usual. A key challenge to understanding the subnational inequities is the lack of quality and up-to-date data on mortality rate, causes of death, and barriers to accelerating mortality reduction.

Particular attention must be paid to—

- identifying barriers to access and use of services
- identifying the multiple vulnerabilities that children and families face, such as being born small or sick, ‘zero-dose’ or under-immunization, undernutrition and wasting, lack of water, sanitation and clean air, poverty and material hardship, parental stress and mental health problems, living in a fragile and conflict-affected setting.
- quantifying resource gaps for effective primary health care delivery, inclusive of community-based health services, to provide high-quality and equitable care.

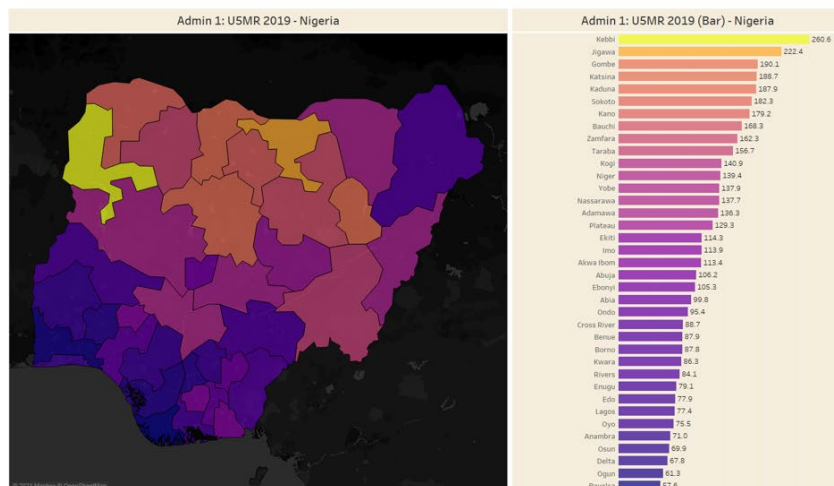
Beyond commonly recognized risk factors for child morbidity and mortality, pre-term and low-birth weight babies who survive the first four weeks remain at higher risk of dying in the 1-59 month period. **Reducing child deaths depends on the delivery of high-quality services across the MNCAH continuum of care and programmatic alignment from pre-pregnancy to pregnancy and birth, postnatal period, and childhood so that every child and mother receives the care they need throughout the life course.**

**Governments opting into the Child Survival Action initiative, supported by their partners, should work to understand the national and subnational drivers of premature deaths in the under-five age group using existing data and taking into account their limitations.** Each country's roadmap to 2030 should include additional investments to strengthen the capacity to generate accurate and specific data for decision making.

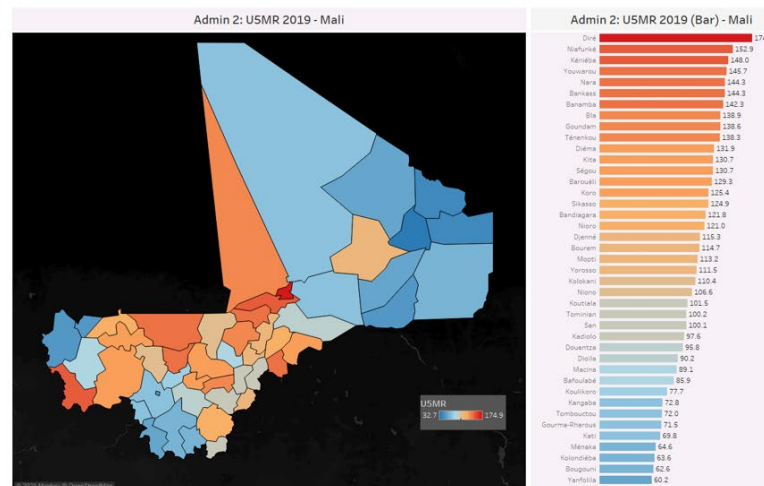
Data are key to characterizing barriers, contextualizing and targeting interventions to reach children and communities at particular risk of under-five mortality. The maps below show examples of extreme regional disparities in mortality rates in Mali, Nigeria and Sierra Leone.

FIGURE 7: Regional disparities in under-five mortality rate in Mali, Nigeria and Sierra Leone, UN IGME 2019, (work in progress, updates can be found at [www.childmortality.org](http://www.childmortality.org))

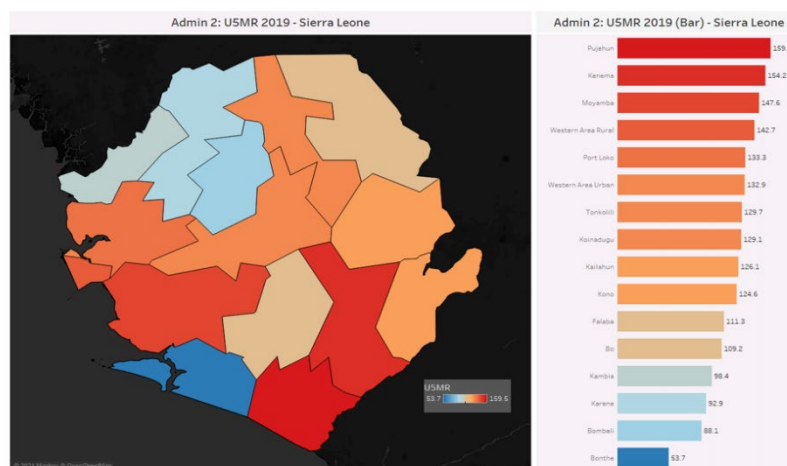
## Nigeria



## Mali



## Sierra Leone



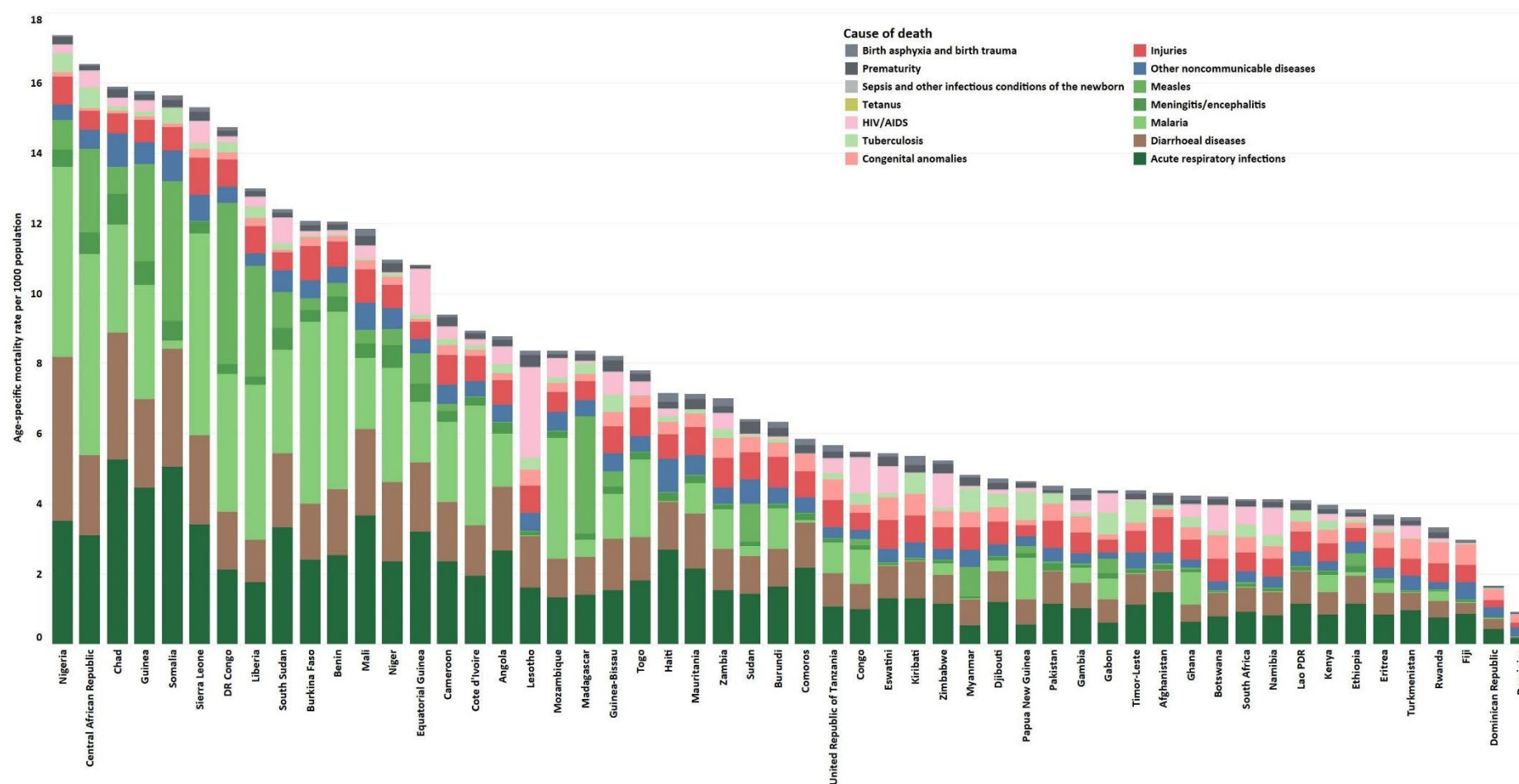
Robust granular data are critical to improved understanding of national and sub-national characteristics and disparities in mortality, causes of mortality, access, and coverage of interventions. Every country needs data-driven analyses to frame actions and develop partnerships to accelerate the reduction of under-five mortality.

## Leading Causes of Death

Beyond the newborn period, pneumonia, diarrhea, and malaria (in endemic countries) remain the leading causes of under-five mortality, often compounded by undernutrition, exposure to HIV, and co-morbidities (Figure 8). These diseases can be effectively prevented and managed in the community and at primary care facilities. However, there continues to be low coverage and low quality of critical, high impact interventions. When complications arise, timely referral, safe transport, and readiness of higher-level facilities are key to effective management of severe childhood illness. However, when referral happens late in the course of an illness, or referral facilities are not ready to manage such cases, families lose confidence in the health system.

**The 54 countries that need accelerated action to meet the SDG child survival target by 2030 require urgent support to prevent and treat pneumonia, diarrhea, malaria, undernutrition and other main causes of child mortality. Reported care-seeking rates for pneumonia and rates of treatment with oral rehydration salts (ORS) and zinc remain low in these countries. More information on subnational inequalities in intervention coverage and integrated care for children is needed.**

FIGURE 8: Leading causes of 1-59 month premature death in 54 countries needing accelerated action, Maternal and Child Epidemiology Estimates, 2019





## What Drives the Leading Causes of Death?

The continued high 1-59 month mortality, with common infections remaining key causes of death particularly among the most disadvantaged population groups, is an expression of inequities and the multiple deprivations children in the high-burden countries face. The drivers are:

**1. An accumulation of risk factors including** poverty, food insecurity/malnutrition, lack of access to clean water and sanitation, air pollution, increasing incidents of fragile/humanitarian contexts, lack of political commitment, and lack of coordination in health service planning and delivery and multi-sectoral collaboration.

**2. Malfunctioning public health systems and limited investment, especially in primary health care and integrated service delivery:**

- a. **Integrated management of childhood illness** has been introduced in 100+ countries, yet implementation has faltered, coverage is unequal, and substantial quality gaps exist. Programs focus on health worker capacity and case management, and less so on prevention, systems strengthening, and community engagement. In most countries, health workers are trained but there is limited support for improving family and community practices and ensuring supplies, supervision and referral care is happening to the highest possible quality.
- b. **Integrated community case management (iCCM)** is not institutionalized in many countries and is not being scaled up.
- c. **Referral systems** and referral level care is suboptimal.
- d. **Vulnerable children** are often not recognized and risk stratified approaches to prevention, management and follow-up after illness are poorly developed and applied.

**In addition, and depending on the context, the private sector (for profit and not-for-profit) plays a key role in service delivery and often expands access to health care for families.**

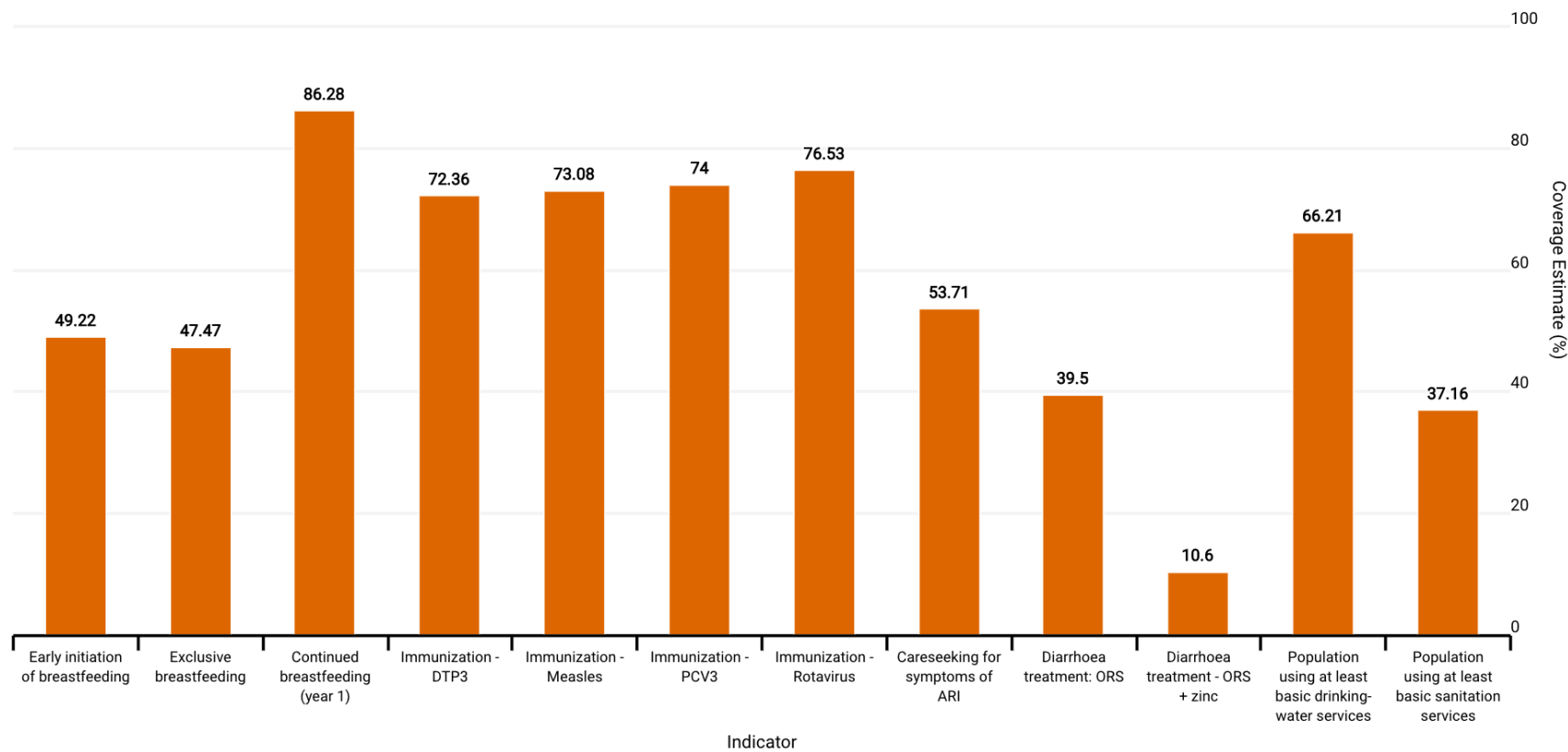
The leading causes of death and the ability of the health system to manage these conditions differ by country and regions within them. Thus, each country needs to understand the causes of death, coverage and quality of existing public and private sector health services, bottlenecks to service delivery in the health system, and all the barriers preventing children and families from accessing health care services. Specifically, timely data collection and analysis to track service use and quality (including the experience of care), and identifying demand and supply barriers for subpopulations experiencing multiple vulnerabilities must be a country-level priority.

## Progress in Coverage of Services for Leading Causes of Death

Available data show low levels of coverage of interventions for childhood preventative and curative interventions in the 54 countries that need accelerated action compared to the rest of the world. Notable is the low coverage of basic sanitation, basic drinking water, care seeking for symptoms of pneumonia, and treatment of ORS and zinc for diarrhea. The higher coverage of immunization services- a well-funded vertical program- points to the importance of strengthening PHC as the basic platform to deliver key interventions to promote, prevent and treat childhood illness equitably. Using PHC to integrate services, including multi-sectoral action, can leverage existing and better funded programs, like immunization, to deliver multiple services. At country level, data systems must be strengthened to include data from the private sector in

routine national health information systems in order to have the complete picture of coverage of services. Beyond coverage, countries need data on the quality of services to determine effective coverage of interventions.

FIGURE 9: Select interventions on the continuum of care: comparison of 54 countries needing accelerated action for SDG3 with the rest of the world (most recent survey, 2016 or later)



## Why Invest in Primary Health Care?

**Investing in primary health care (PHC) is essential to ensure equitable provision of high-quality child health services** to prevent and treat the main childhood diseases in an integrated way, and accelerate reduction of under-five mortality during the newborn period, infancy and young childhood (see Figure 10 below). In addition, PHC services must be strengthened to withstand the impact of COVID-19, and similar shocks to enable progress toward the SDG target 3.2 of 25 or fewer under-five deaths per 1,000 live births by 2030.

Synergies across the many global strategies, initiatives and country-level programs—like the Global Alliance for Vaccines and Immunizations 5.0, GFF, and the Global Fund for TB, HIV, and Malaria—must be leveraged to treat the leading causes of preventable and treatable deaths in the under-five age group. PHC is a platform that can deliver equitable health interventions for children. If it is well funded and strengthened, it will support the delivery of interventions from these complementary programs creating a seamless health system to meet the health needs of children and their families. The Astana Conference in 2018 reaffirmed the prioritization of people centered, multi-sector, life course designed primary health care. At its core, primary health care approach includes three components:

- Meeting people’s health needs throughout their lives through integrated service delivery.
- Addressing the broader determinants of health through multi-sectoral policy and action.
- Empowering individuals, families, and communities to take charge of their own health.

The CSA initiative fits perfectly within the PHC approach reaffirmed at the Astana Conference in 2018 to support national, subnational, regional, and global efforts to achieve universal health coverage.

## Essential Interventions and Services to Accelerate Reduction of under-five Mortality

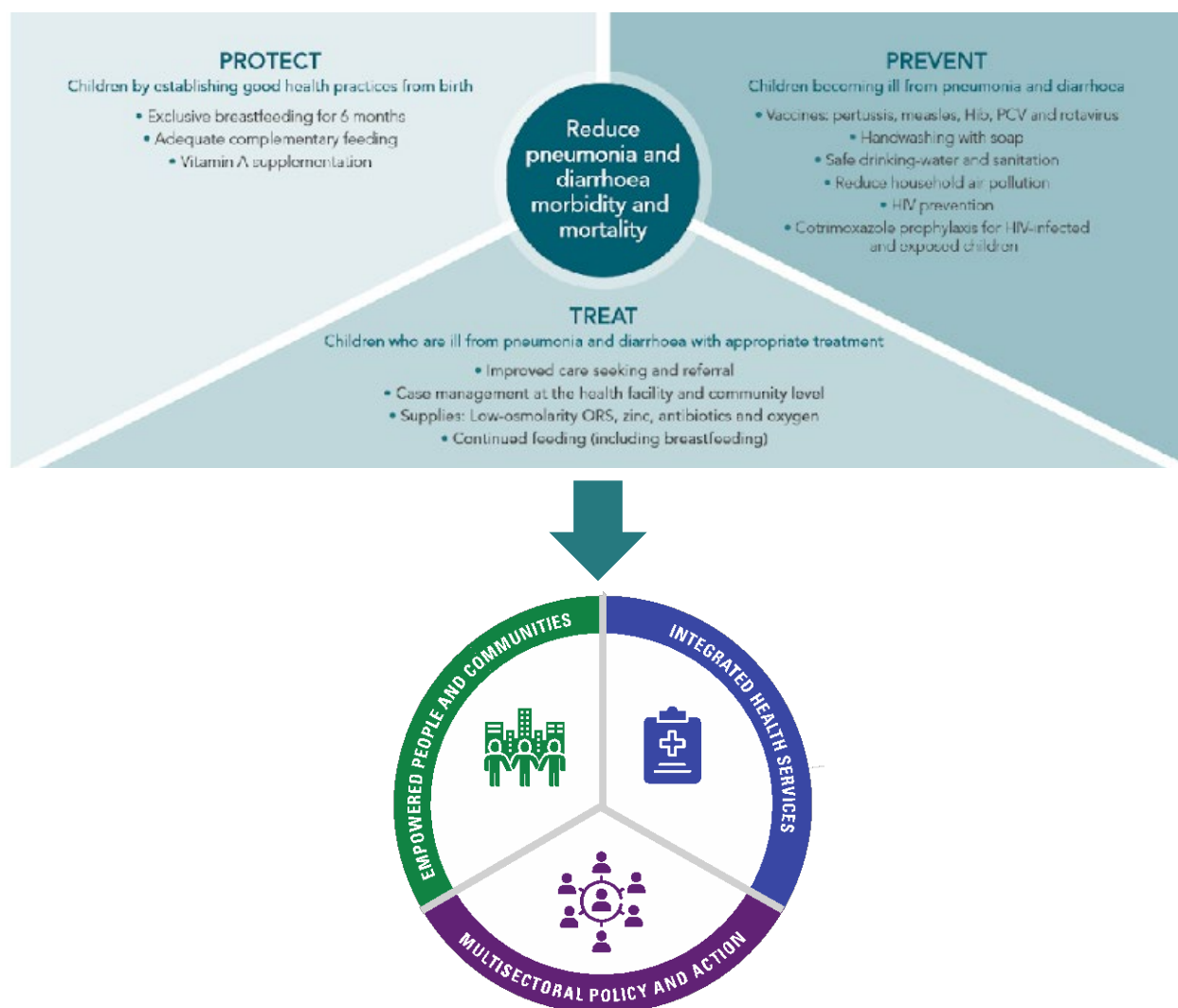
Building on the commitments from EPMM to ENAP, the CSA initiative is a necessary next step to draw attention to the unfinished agenda of reducing 1-59 month mortality in countries where it is getting less attention. These three initiatives, when linked and implemented at the country level, are critical for mothers, newborns, and children to live, thrive, and have a voice to influence society or the next generation

The Global Action Plan for the Prevention and Management of Pneumonia and Diarrhoea (GAPPD), released in 2016, provided a sound template for action to protect, prevent, and treat illness.<sup>16</sup> Its principles and actions continue to be relevant for completing the unfinished agenda of child survival.

---

<sup>16</sup> [Ending Preventable Child Deaths from Pneumonia and Diarrhoea by 2025](#)

FIGURE 10: GAPPD – A platform for delivering effective interventions equitably through PHC



At the country level, key strategies to deliver these interventions for children in a continuum are:

- Integrated management of neonatal and childhood illness (iCCM and IMNCI) at the community and primary care facility level. These strategies include health promotion and prevention.
  - Improving family and community practices
  - Improving provider skills
  - Health systems support
- Emergency Triage, Assessment, and Treatment, including ensuring referral to secondary and tertiary care when required.

Leveraging these delivery platforms and adding outreach services will expand access to promotional and preventive services. Secondary level care is essential to delivery of the continuum of services particularly for the neonatal period and the management of severe illness in childhood. The initiative focuses on child survival, but the interventions addressing mortality reduction will support overall health and development of children and form the basis for the thrive agenda in the countries needing accelerated action. Table 2 below is organized according to the three main components of GAPPD and summarizes essential interventions, the delivery platform, and their impact on child survival.

TABLE 2

	Intervention	Level of Care/ Platform				Impact on top causes of <5 deaths												
		Household	Community based and/or outreach services	PHC facility	Referral facility (primary and/or secondary)	newborn survival	pneumonia	diarrhea	malaria	HIV	malnutrition/ wasting	TB	measles	injuries	Meningitis	congenital anomalies	Tetanus	Pertussis
PROMOTE	• exclusive breastfeeding	X	X	X		X	X	X			X	X						
	• adequate complementary feeding	X	X	X			X	X		X	X	X						
	• vitamin A supplementation, zinc, food supplementation	X	X	X						X	X	X						
PREVENT/ PROTECT	• Vaccination (BCG, DPT, PCV, Hib, Measles, Rotavirus, Malaria to come)		X			X	X						X		X		X	X
	• WASH (hand hygiene, safe drinking water, sanitation)	X	X	X	X						X							
	• Insecticide treated bed nets	X	X	X														
	• Indoor residual spraying	X	X															
	• Co-trimoxazole for HIV-positive children			X						X								
	• Preventive therapy for TB exposed children											X						
	• reducing indoor air pollution	X	X	(X)														
	• reducing ambient particulate matter pollution																	
TREAT through integrated service delivery models	• Detect and treat childhood infections (including pneumonia, diarrhea, malaria) and refer children with danger signs (IMNCI, iCCM): Antibiotics, anti-diarrheals, anti-malarials, hypoxemia measurement		X simplified protocols (iCCM)	X		X	X	X	X		X				X			
	• Detect and treat possible serious bacterial infections in neonates (IMNCI): antibiotics, hypoxemia measurement			X		X	X											
	• Detect, (refer), treat moderate and severe malnutrition: antibiotics, RUTF		X simplified protocols (MAM/SAM)	X		X	X	X			X	X						
	• ART for HIV positive children			X	X					X		X						
	• TB treatment for children diagnosed with TB			X	X													
	• Manage severe and/or complex childhood illness: factor in oxygen for ARI/pneumonia and other use cases			(X)	X	X	X	X			X				X	X		
	• Manage child injuries			X	X	X								X				