

UNICEF ANNUAL REPORT 2006

Dr. Peter Salama, Chief of Health for UNICEF discusses the UNICEF programme on maternal, neonatal and child survival

Q: Please discuss the highlights of UNICEF's programme on maternal, neonatal and child survival in 2006.

Firstly we've seen a continuous improvement on immunization, and coverage is now more than 78 per cent globally. More than 100 countries have reached the 90 per cent national coverage target. One of the most important achievements has been on measles. The [measles partnership](#) [that] has released results this year that show that measles-specific deaths have decreased globally by more than 60 per cent, and within Africa by more than 75 per cent. This represents the first time that the UN and the international community has actually not only reached an international health target, but surpassed it. Measles is well on the way to becoming a rare disease in developing countries.

We have seen tetanus deaths decline from around 200,000 deaths to 150,000, and the number of polio-endemic countries down from six countries to four. We've seen a real drive towards integrated programming. For immunization we've seen the use of polio campaigns and measles campaigns for the delivery of other interventions, particularly vitamin A, deworming tablets and insecticide-treated nets. In fact, that strategy is becoming more formalized and in fact most African countries now at least once a year do something called Child Health Days or Weeks. Many Asian countries are [also] doing that now. It is a systematic way...[to] get to as many children as we can with a group of services that affect the key causes of mortality and disability. Vitamin A is also increasing in coverage.

Insecticide-treated nets for malaria has been a major push in the last year. UNICEF alone has distributed more than 24 million nets through campaigns and through other activities, and coverage is likely to be shown in the latest round of [MICS \[Multiple Indicator Cluster Surveys\]](#) to have increased dramatically. On other aspects of [malaria](#), we've seen big policy changes, moving from drugs that the malaria parasite has become resistant to, like chloroquine, to the newer drugs, which are much more effective.

There has been a big drive on integrated programming. Using models such as the [Accelerated Child Survival and Development programme](#), which began in four major countries in West Africa – Ghana, Benin, Senegal and Mali. In these countries, building on the interventions and systems that were already in place, they were supported with supervision, with supplies and commodities, and, at the community level, programmes were expanded. The preliminary results demonstrated estimated reduction in under-five mortality of about 20 per cent. We're now confirming those results with a formal

evaluation being undertaken by Johns Hopkins. Many of the principles of that programme are already being rolled out in other countries in East[ern] and Southern Africa as well as West Africa. And that programme has been used as the basis for another event that happened in 2006, which was the All Africa Meeting, where all the Representatives from UNICEF for Africa were brought together to review experience on integrated community-based health programmes, review the evidence, and look at how we can rapidly scale-up to meeting some of the health-related [MDGs \[Millennium Development Goals\]](#). When we look back at that meeting in future years we will see that as a turning point for UNICEF in really helping us with our partners the health-related MDGs.

Q: What were the main challenges?

There are 60 countries that have been called ‘The Lancet child survival countries’, and these are the countries either with the highest under-five mortality or the highest absolute number of deaths of children. Those countries also happen to be the countries with the poorest health systems. So, the constraints are really the fact that we’re trying to get the most results from the countries that have the weakest infrastructure. In many countries the infrastructure has been further exacerbated by two major factors: one is conflict. The other has been the HIV/AIDS pandemic. We have also have problems in rapidly scaling up. Exclusive breastfeeding rates are still at only about one third globally, and even some of the interventions where we’ve really highlighted in advocacy terms in the last couple of years, like [paediatric treatment of HIV/AIDS](#), and cotrimoxazole prophylaxis for HIV exposed and positive kids, the coverage is still really lagging behind.

In all of those 60 countries, but even in those countries that on the aggregate national level are doing quite well, there are always marginalized, vulnerable populations. One of our key constraints it to reach those unreached populations. Other barriers are the more mundane but still important ones of funding. This is overall resource gaps globally for child survival, not just for UNICEF’s programmes, but for all of our partners. We need to fill that gap both through external, western donors but also through advocacy for programme country governments to meet their previous commitments on expenditures in the health sector. And one of the most important principles are the [Abuja Targets](#) [but] most countries are still way behind that target. A[nother] major constraint is the whole area of human resources for health. We’re recognizing that to deliver on our health MDGs, we really have to get skilled health workers in place. We’re not just talking here about doctors and nurses. We’re really talking about skilled birth attendants [and] community health workers with rigorous training who can help with our integrated community-based health programmes.

Q: In 2006, two countries virtually eliminated polio virus transmission, and the remaining four endemic countries reduced the spread of polio. How were these countries able to do this? How did the work of UNICEF and partners contribute to these successes? What actions are being taken to ensure that these countries remain polio-free?

Overall, we are behind on the [polio eradication goal](#), but we also feel that we are making progress. In 2006, two countries that were formally on our endemic list for polio have now been removed. They are Egypt and Niger. There are four remaining endemic countries: Afghanistan, Pakistan, Nigeria and India, and they all present different types of problems in the eradication scenario. The last remaining countries and reservoirs of a disease that needs to be eradicated are always the most difficult, and polio is no exception. Some work published last month [April 2007] by a group at Harvard suggested that even if we were to change strategies at this point in polio eradication and go for a different strategy, such as a control strategy, it would be far less cost-effective and [we] would actually end up seeing resurgence in the number of polio cases if we didn't continue our charge towards eradication.

In terms of the last four remaining countries, we have three major distinct problems here. In Afghanistan and Pakistan, we have a problem predominantly of a lack of security. One of our key constraints to eradication is actually getting our vaccinators to the populations that need the polio vaccine. We are working closely with the leaders of those countries to guarantee safe access for health workers to the children that need polio vaccine. In India, we have a different set of issues. It's [the problem] one of population density, poor water and sanitation and a real need to be very quick in covering children [since new huge cohorts of children are born every month]. In Nigeria [the issue is] an epidemic that's focused in the north of the country. In the past we've had religious leaders that have come out with messages that have not supported our polio eradication. Over the last couple of years the religious leaders, including in the north, have been very supportive. We think we're turning the corner in Nigeria.

So, separate problems and separate constraints in each of those four countries, but we believe that technically it is very possible to eradicate polio in the coming years, but we are going to need to focus very heavily on those countries, ensure that the funding is in place, ensure that the supplies are in place, and ensure that the communication strategies are very effective in keeping people on board.

Two interesting aspects of the programme that are relatively new. One is the work on a more effective vaccine in the last year or two. It has helped achieve the success in Niger and Egypt. It's called the monovalent polio vaccine and rather than targeting the three strains of the virus that the previous trivalent vaccine targeted, it just targets the one that is most commonly left in the endemic countries. We've seen from our results that actually targeting one strain that is the most common is much more efficient in bringing up children's immunity.

The other has been particularly in the Nigeria programme. By combining polio vaccinations with other interventions – in the case of Nigeria it's been measles, deworming tablets and vitamin A – and some thought now into linking in with bednets [insecticide-treated mosquito nets], we've seen that communities are much more receptive to having their children receive the drops, because even if they don't recognize polio as a major killer of children any longer, they certainly recognize measles and malaria as major killers of children in their communities. That's been an important way of regaling support for the polio eradication programme.