United Nations Children’s Fund
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Thematic discussion on results and lessons learned in the medium-term strategic plan focus area 1: Young child survival and development

Background document

I. Young child survival and development: vast challenges and opportunities

1. Young child survival and development (YCS&D) is the largest focus area of UNICEF’s medium-term strategic plan (MTSP) in terms of budget and programmatic scale, including in emergencies. This focus area encompasses nutrition, health, water, sanitation and hygiene, and early childhood care and development, and supports the achievement of MDGs 1, 2, 4, 5, 6 and 7. UNICEF’s work in this area influences and shapes discourse and action in global child survival, growth and development, linking the development of evidence-based national policies, legislation, plans and budgets with large-scale implementation of high-impact interventions. In emphasizing a results-driven approach, UNICEF contributes to shifting child survival strategies towards measurable results and approaches that have the potential to shorten the path to achieving the MDGs.

2. This paper, providing background for the discussion on focus area 1 at the 2011 second regular session of the Executive Board, offers an overview of the situation of children, refinements in programme strategy, and examples of results, emerging evidence and lessons learned over the past five years. It also explores new and innovative forms of engagement in the area of young child survival and development.

II. The situation of children: a mixed picture

3. Progress in the area of young child survival and development is captured by under-five mortality, which has declined by one third in developing countries, from 99 deaths per 1,000 live births in 1990 to 66 deaths per 1,000 live births in 2009, with annual under-five deaths reduced from 12.5 million in 1990 to 8.1 million in 2009. Of the 68 countries that account for 90 percent of these deaths, 19 are projected to achieve MDG 4. Over the past two decades, the causes of deaths of children under 5 have changed, reflecting the success of interventions that include immunization, vitamin A supplementation, and malaria prevention. For example, measles, which accounted for 7 per cent of under-five deaths in 1990 now accounts for only 1 per cent of these deaths.
4. Worldwide, 41 per cent of the estimated 8.1 million deaths of children under five are due to pneumonia, diarrhoea, and malaria – diseases for which there are proven, affordable and highly effective interventions. Yet these interventions are not reaching children who need them, especially in the highest-burden countries. These countries are mainly in sub-Saharan Africa and Asia, regions that account for more than half of child deaths.

5. These conditions place an enormous burden on families, particularly the poorest and the most vulnerable. In the case of pneumonia, there are an estimated 156 million episodes and 1.8 million deaths annually among children under five. Diarrhoea accounts for about 2.5 billion cases and 1.5 million child deaths annually. Malaria accounts for almost 250 million cases and more than 800,000 child deaths every year. About 60 per cent of the global burden of these cases and deaths are concentrated in a limited number of countries, including Afghanistan, Bangladesh, China, Democratic Republic of the Congo, Ethiopia, India, Kenya, Nigeria, Pakistan and Uganda.

6. Data also show that as other causes of death have diminished, the proportion of newborn deaths to all under-five deaths increased from 36 per cent in 2000-2003 to 41 per cent in 2008. A quarter of newborn deaths occur in the first 24 hours of life, often at home. Tackling these deaths requires more complex interventions. This area, then, is the next frontier in child survival efforts.

7. Undernutrition is directly associated with these deaths. More than one third of all under-five deaths are attributable to undernutrition. Yet action to tackle undernutrition continues to be insufficient. At present, no more than 62 of the 118 countries are on track to halve the number of underweight children by 2015, one of the two indicators used to assess progress against MDG1, target c. Sub-Saharan Africa and South Asia carry the highest burden of undernutrition, which has often been a low priority in national development plans, except in situations of crisis. Stunting, which reflects chronic undernutrition in young children, affects 195 million children – or about one in three children across developing countries. Stunting is closely associated with immediate impacts on reduced learning outcomes, which in turn lead to reduced productivity and income-earning capacity in adult life. Although breastfeeding is the most effective preventive intervention in terms of its impact on under-five mortality, only 37 per cent of babies are exclusively breastfed in the developing world. Iodine deficiency, which is linked to challenges in brain development, is still a threat. About 41 million newborns are unprotected each year because of inadequate intake of iodine by their mothers.

8. There has been remarkable progress in access to improved water sources, placing the world ahead of the MDG schedule. This is, however, mainly due to developments in China and India. Some 1 billion people, mostly in sub-Saharan Africa and South Asia, still lack access to improved water sources. By contrast, there has been less progress in the area of sanitation: globally, 2.6 billion people do not have adequate sanitation, with South Asia having the highest number of people practising open defecation. Combating diarrhoea, the second greatest cause of under-five mortality in developing countries, requires concerted efforts to ensure safe water, sanitation and hygiene for unreached populations. The lack of improved facilities in communities and schools has other far-reaching consequences for children. One consequence is parasitic worm infections, which retard children’s physical and intellectual growth and affect 47 per cent of children aged 5-9 years in developing countries. Another consequence especially affects girls, who in some countries miss up to 20 per cent of school days.

9. Little progress has been made in reducing maternal mortality. The number of maternal deaths declined from roughly 546,000 in 1990 to 385,000 in 2008. The maternal mortality ratio fell in the same period from 400 deaths per 100,000 live births to 260 deaths per 100,000 live births. Nevertheless, the number of deaths remains unacceptably high. Most maternal deaths can
be prevented if births are attended by a professional and are regularly supervised, have the appropriate equipment and supplies, and are referred in a timely manner to emergency obstetric care when necessary. Maternal health is a direct determinant of neonatal survival, and the death of a mother substantially increases the risk of death for her newborn child. In countries with a high HIV burden, testing for and treating HIV/AIDS is another critical prevention intervention for saving the lives of mothers and newborns.

10. Worldwide, some 200 million children under five are at risk of impaired cognitive and social and emotional development. This is largely because basic interventions for holistic early childhood care and development, including elements of early stimulation and learning, are not sufficiently funded and mainstreamed into sectoral programmes for children. In general, outcomes for children in early childhood care and development are characterized by wide disparities, with children in the wealthiest quintiles normally capturing better access to care and development. This inequality perpetuates the cycle of poverty.

11. Conflicts, violence and recurring large-scale natural disasters are significant impediments to progress towards the MDGs. As a matter of fact, no low-income fragile state has yet achieved a single MDG. Progress is slow in these countries, where generally a large proportion of children are undernourished, miss out on school and die from preventable causes. Paradoxically, it is in these same places that integrated child survival and development action, guided by real-time analyses and updates, holds the promise of synergistic results for the neediest and most vulnerable children and their families.

12. Several key factors support the integrated approach taken in the MTSP focus area on young child survival and development. These include the interplay of poor nutrition and disease, the clear role of water, sanitation and hygiene (WASH) in disease prevention and nutritional outcomes, and the proven benefits of early childhood care and development programmes. Through the life cycle of pre-pregnancy, pregnancy, the neonatal period, infancy, and early childhood, a series of critical interventions are needed for the best possible outcomes for children and mothers. These interventions link health, nutrition, WASH and early childhood care and development, and can be packaged and delivered through the same channels to maximize outreach and impact. The integrated nature of YCSD action and adjustments being made for greater impact are discussed further below.

III. The main challenge: increasing inequalities

13. Seeing YCSD action through the lens of equity and connecting the Millennium Declaration and MDGs with the human rights-based approach to programming reveal both challenges and opportunities for the poorest and most vulnerable children. Despite the many gains, a substantial number of women and children still die from easily preventable causes, burdened with excessive morbidity and mortality, higher levels of undernutrition in a context of deepening disparities. The concentration of mortality, morbidity and undernutrition among the poorest and most disadvantaged children is especially stark in sub-Saharan Africa and South Asia. For example in 1990, sub-Saharan Africa accounted for around 31 per cent of global under-five deaths. By 2009, an estimated 49 per cent of all under-five deaths occurred in this region alone. Wide disparities within countries, driven by wealth indices, geography, sex and rural/urban factors, further undermine efforts aimed at faster reductions in under-five mortality. A UNICEF analysis of data from international household surveys disaggregated by wealth quintiles for 37 countries showed that in 22 of these countries more than 50 per cent of under-five deaths occur in the two poorest quintiles; and in 12 countries the proportion of under-five deaths was at least 30 per cent higher in the poorest two quintiles compared with the richest two quintiles.
14. Such disparities are evident across the spectrum of child growth and development indicators. In developing countries, 40 per cent of children in the poorest wealth quintiles are underweight compared to 15 per cent of children in the richest quintiles. Children in rural areas are twice as likely to be underweight than those living in urban areas. Analysis in WASH reveals that the poorest people in sub-Saharan Africa are more than 15 times as likely as the richest to practice open defecation, with the effect that the poorest are more susceptible to frequent waterborne diseases. Seven out of nine people without improved drinking water sources live in rural areas, where the chore of collecting water from distant sources has negative implications for gender equality in the light of women’s workload and safety.

15. In terms of coverage with key interventions, similar patterns are found through the continuum of care from pregnancy to early childhood. For example in the developing world, just one third of rural women attend four or more antenatal care visits, the number of visits recommended by the World Health Organization, compared with two thirds of urban women. Almost three times as many women from the upper wealth quintile than the poorest quintile are likely to have a skilled birth attendant, a statistic that in South Asia rises to five times more. Such disparities continue even after birth. Children in the richest households are 60 per cent more likely than children in the poorest households to sleep under insecticide-treated mosquito nets, and they are 70 per cent more likely to receive antimalarials when they have a fever. More than 70 per cent of all the unimmunized children now live in just 10 countries.

16. In highlighting opportunities for action, UNICEF is using disaggregated data and in-depth analysis to place the challenge of addressing inequities center stage in the countdown to 2015. Too often such inequities have been dismissed as an unfortunate consequence of the need to reach goals and targets in the most efficient manner possible, in the belief that achieving equity is too expensive and slow. In “Narrowing the Gaps to Achieve the Goals”, a 2010 study by UNICEF, equity-focused approaches to child survival and development have been shown to be not only the most practical but also the most cost-effective way of meeting the MDGs.

17. This study modelled a number of different equity-focused strategies in the area of young child survival and development and demonstrated that addressing inequities is not only “right in principle” but also “right in practice”. The study concluded that, for every dollar invested, more lives can be saved among the most deprived than among the least deprived children. These findings not only sharpened the focus on the issues affecting the most disadvantaged children but also brought renewed attention to countries where national averages mask profound internal disparities. Such attention is particularly vital for saving lives in emergencies and humanitarian contexts. It is directed primarily at the most vulnerable and neediest children and is based on assessed needs – without differentiating between host communities and displaced populations.

IV. Addressing inequalities: global, national and local strategies

18. Disparities play out in different ways according to country contexts. In low-income, high-burden countries, the majority of the population is likely to be poor and lacking access to essential services. In middle-income countries, levels of deprivation closely mirror the economic status of families, with entrenched pockets of deprived populations closely associated with factors such as ethnicity, gender and geographic location. Another typology is presented in countries with humanitarian and emergency situations, where deprivations can be especially stark and programme operations constrained by unfolding crises. In each context a unique set of strategies, defined with national and local partners, is required to address disparities.

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1 The study showed that it is possible to accelerate progress towards the MDGs by taking an equity approach prioritizing the vulnerable and marginalized. The Executive Director summarized the key elements of the approach when he introduced the study to the UNICEF Executive Board at its second regular session of 2010.
19. At the global level, UNICEF is deploying evidence-based strategies to help to shape prices and markets so that developing countries have greater access to vaccines, including new vaccines, essential medicines such as antiretroviral drugs, and other essential products to enhance child survival. One example is the active role UNICEF continues to play in the GAVI alliance in the design and implementation of the ‘pneumococcal advance market commitment pilot’. This is a public-private initiative aimed at improving the availability and affordability of pneumococcal vaccines for low- and middle-income countries. UNICEF is a lead actor in establishing a transparent bidding system for vaccines and ready-to-use therapeutic foods and has supported the expansion of the number of suppliers from 1 in 2006 to 16 in 2011. These efforts involve supporting local production. Such support contributed to a 24 per cent increase in the purchased volume of ready-to-use therapeutic foods from local suppliers in developing countries in 2010. Increased reliance on local suppliers improved product availability, quality, price transparency and shorter lead-times for delivery. In WASH, the development of the code of practice for cost-effective boreholes has facilitated cost reductions in drilling boreholes. This is particularly the case in several countries in sub-Saharan Africa, where costs have been reduced by more than one third.

20. Previous efforts to provide universal coverage in areas of child survival, nutrition and early childhood development focused mainly on the expansion of facility-based care to larger geographic areas. This approach to achieving universality has not been sustainable and has also deepened inequities in some countries. The lack of sustainability is largely due to the relatively high costs of building and maintaining the infrastructure and to the lack of skilled health professionals to serve marginalized and unreached populations. In a few countries where this approach has been applied consistently there has been greater access to basic maternal, child, and other MDG-related health services for a sizeable share of the population. However, in these countries, many other segments of the population have continued to lie beyond the reach of services. Mostly, these have included families with very low incomes in urban slums and in rural areas. Moreover, under this conventional approach, new interventions tend to reach those already served by the existing health care infrastructure, further widening inequalities. The 2010 UNICEF study pointed to widening gaps connected with use of the conventional approach: of the 24 countries making the most progress in reducing under-five mortality since 1990, 16 experienced widening disparities in mortality between the richest and poorest quintiles.

21. Using the findings of the Narrowing the Gaps study and lessons learned from conventional approaches described above, YCSD strategies in UNICEF have been reshaped to reorientate programmes to address inequities more effectively. Support is being provided to countries to identify the most deprived children and communities and to assess the bottlenecks and factors that exclude these segments of the population from accessing care and services. The aim is to design the most appropriate and equitable solutions that work more from the demand side. Additional funding is being provided to support solutions at the community level that will enable families to have regular access to outreach or community-based care and to adopt improved YCSD practices and behaviours.

22. Innovations in support of this equity-based strategy include expanding the numbers, and refining the job descriptions, of community health workers; utilizing new tools and technologies to allow community workers to safely diagnose and treat some important causes of newborn and child deaths; and expanding services offered through ‘child health days’ and social protection strategies such as cash transfers. When combined with a focus on increasing demand for services and intensive engagement with communities to change detrimental social norms and behaviours, such innovations have led to remarkable, equitable reductions in mortality rates in some countries. These approaches, many of which are shared as part of good practices in South-South and
other forms of cooperation, offer further options in the journey towards achieving universal coverage.

23. With UNICEF support, many countries are strengthening the capacities of community health workers to manage severe acute malnutrition and common diseases such as diarrhoea, malaria and pneumonia. Currently, 55 countries are implementing community-based strategies for the management of severe acute malnutrition, with UNICEF providing the bulk of ready-to-use therapeutic food requirements. In the past, treatment of severe acute malnutrition was largely possible only for children who had access to facilities. UNICEF is also supporting strategies to expand the use of therapeutic zinc supplements in diarrhoea treatment, the use of micronutrient powders for home fortification of complementary foods, and the use of antibiotics by community health workers to treat pneumonia.

24. Rapidly reducing undernutrition and addressing the complex challenges that underlie the high rates of maternal and newborn mortality require investments in strengthening delivery systems. UNICEF is working closely with other development partners and national counterparts to identify and map out the bottlenecks, gaps and breakdowns in the delivery of essential services for the poorest and most marginalized children. Health systems in developing countries have an estimated deficit of 2.4 million skilled health workers, including some 350,000 midwives. The role of these workers and midwives is vital to maternal and newborn health, especially where progress towards the MDGs is slowest. Procurement and supply management systems also require strengthening to ensure that critical, high-impact commodities are available to all who need them at the community level.

25. In many developing countries, the use of outreach services to provide a mix of preventive and scheduled interventions – such as immunization, vitamin A supplementation, deworming and provision of insecticide-treated mosquito nets – has significantly increased through the strategy of child health days (or weeks). Child health days, which complement the health care system, provide outreach services for delivering scheduled high-impact interventions such as immunization, vitamin A supplementation, malaria prophylaxis in pregnancy and treatment for common childhood illnesses. By 2010, UNICEF and its partners were supporting more than 50 countries to conduct child health days, compared with only 2 countries in 1999. In sub-Saharan Africa, this strategy has been effective in expanding coverage of life-saving interventions. This has been accomplished through strengthening the capacities of counterparts in areas such as decentralized training, planning, in-country logistics and the provision of essential commodities. Regarding supplies, one of the most dramatic results has supported malaria control: the delivery of 200 million long-lasting insecticide-treated bed nets to African countries from 2007-2009. This number represents 57 per cent of the 350 million nets needed to achieve universal coverage.

26. As part of systems-strengthening and emphasizing the demand side, UNICEF is working with families and communities to promote the adoption of positive behaviours in child and maternal care. These include exclusive breastfeeding, hand-washing, sleeping under insecticide-treated nets, and spending time playing with children and providing them with cognitive stimulation. Exclusive breastfeeding is directly linked to the reduction in the death toll of children under five by an additional 13 per cent and has the potential to positively transform the mortality landscape for children. Yet only 37 per cent of infants below the age of six months in developing countries are being exclusively breastfed. The number of countries implementing community approaches to total sanitation, considered to be the most effective and equitable approach to eliminating open defecation, more than doubled to 49 countries since its introduction in 2008.

27. Other demand-side strategies being used to promote equity include the following: (a) task-shifting and improving remuneration for grassroots health workers where infrastructure, transportation and outreach are limited; (b) social marketing and mass media campaigns that in-
form and motivate communities to use services; (d) elimination of user fees; and (e) cash transfers to the most marginalized.

V. The power of partnership: leveraging investment and action for children

28. Investment in health services for children and women is crucial. Yet the world’s poorest countries face an annual estimated funding deficit in this area of some $26 billion in 2011, a figure expected to rise to $42 billion in 2015. In WASH, the UN-Water Global Annual Assessment of Sanitation and Drinking-Water reported in 2010 that the median WASH spending in a sample of 20 developing countries was only 0.48 percent of gross domestic product. Official development assistance for WASH fell relative to health and education sectors from 1998 to 2008. The share of assistance for basic water and sanitation systems for unreached populations fell from 27 per cent of total assistance to 16 per cent from 2003 to 2008. Clearly, more and better-targeted investments are needed in YCSD.

29. One essential way UNICEF has promoted targeted investment and sustainable results in YCSD is by engaging in strategic partnerships to support programmes for children, including partnerships with governments of developing countries. As one example, by providing catalytic funding at country level to improve the quality of proposals for funding rounds of the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNICEF helped to boost the success rate for malaria proposals from 20 per cent of proposals in 2005 to an unprecedented 89 per cent in 2010. In 2010, through its engagement in the global Public-Private Partnership for Handwashing with Soap, UNICEF supported 87 national campaigns promoting hand-washing with soap, reaching an estimated 450 million people. Through efforts to scale up nutrition programmes, new compacts to prioritize nutrition in national development plans have been signed recently in a number of high-burden countries such as Bangladesh, Democratic Republic of Congo, Ethiopia, Haiti, Nigeria, and Pakistan.

30. For investment planning UNICEF is assisting some 50 countries to analyse context-specific obstacles, bottlenecks and funding gaps, to identify remedial actions, and to estimate additional financial requirements for achieving child survival goals through special-purpose budgeting for investment cases. Using modelling tools such as the marginal budgeting for bottlenecks, and in close collaboration with national counterparts, a number of these investment cases have been prepared and serve as advocacy platforms to mobilize additional domestic and external resources to achieve the MDGs. An investment case developed under the auspices of the African Union shows that in Africa the minimum level of additional investment needed over the period 2011-2015 to achieve the health MDGs is $84 billion. A similar 2009 investment case for the Asia and Pacific region showed that at least an additional $5 billion will be required annually up to 2010 – increasing to an additional $10 billion by 2015 in order to reach MDGs 4 and 5. These investment cases are now being refined to achieve greater equity focus and will be fundamental for leveraging domestic resources.

VI. Programming for results: equity-focused monitoring and evaluation

31. The re-focus on equity in YCSD programming requires new and additional investment in monitoring, especially in countries at the district and grassroots levels. The nature and scope of this work are described in a new conceptual framework for monitoring strategic result areas – the ‘monitoring cup’, which is being refined for country programme action. The approach used by UNICEF to analyse and monitor improvements in coverage of key interventions is based on a bottleneck analysis framework. There are two types of determinants for coverage. The first type is supply-side determinants, such as availability of essential commodities, availability of human
resources and geographical access. All of these need to be present at the same time and place in order for services to be effective. The second type encompasses demand and quality determinants. These reflect the actual utilization of existing services and the degree to which interventions are delivered with the minimum quality conditions necessary to ensure the expected impact. An equity-focused strategy aims to ensure that all these determinants are being taken into account in an integrated way. Analysis of the determinants is key to identifying the causes of bottlenecks so that strategies can be devised to overcome them. Once these strategies are in place, coverage determinants need to be closely monitored.

32. Based on this methodology, UNICEF has been selecting a number of Strategic Result Areas (SRAs) and related indicators for YCSD. These SRAs, which form a subset of the MTSP focus areas and targets, will be monitored frequently in the countdown towards 2015. Monitoring of field-level data and evaluation of progress on bottlenecks and achievement of the MDGs will be informed and complemented by household surveys undertaken every three years – and at shorter intervals in selected countries. Together, these tools will help UNICEF and its partners to ascertain whether expected results are materializing for the poorest and most marginalized children.

VII. Looking forward: greater focus on the “how”

33. The two main challenges in YCSD are widening equity gaps and unequal progress towards YCSD-related MDGs. Within these broad challenges are a number of issues that will continue to dominate action: newborn deaths, which now make up roughly 40 per cent of under-five mortality, maternal mortality, stunting, pneumonia, diarrhoea and malaria. The latter three are diseases that remain the main killers of children and together account for about 40 per cent of child deaths in the post neonatal period.

34. UNICEF and its partners, including governments of developing countries, are pursuing intensified approaches to addressing maternal and newborn deaths, combat undernutrition and prevent the three diseases. New vaccines against pneumonia (pneumococcal) and diarrhoea (rotavirus) will be introduced in many countries in the coming years through GAVI financing, while efforts to increase coverage with insecticide-treated mosquito nets are expected to contribute to a decline in malaria. There is, however, an urgent need to simultaneously expand coverage of effective treatment with simple inexpensive products. These include zinc and oral rehydration solution, which together cost $0.50 per treatment dose, in order to prevent the majority of diarrhoea deaths. Antibiotics such as amoxicillin can prevent the majority of pneumonia deaths and cost about $0.30 per treatment dose. Artemisinin-based combination therapies can prevent malaria deaths at a cost of less than $0.80 per course of treatment on average. While offering hope for the treatment of many millions of children, these interventions, are, however, reaching only a small proportion of those who need them the most. It is imperative to close the treatment gap as quickly as possible if the health-related MDGs are to be met by 2015.

35. As the “whats” of key interventions in YCSD are increasingly clear, future efforts will be devoted to the “hows” of reaching the bottom quintile of society and of improving the quality of the programming process. Anchoring the equity strategy at field level in national development plans and in government priorities will better secure political commitment and enable equity-focused policy adjustments, influence budget outlays, determine investment choices for national capacity development, and so on. As research and knowledge management in UNICEF become more robust, they will further contribute to understanding the “hows” of working more effectively with partners at all levels to achieve the Millennium Development Goals with equity and to sustain progress. Research and knowledge management will be especially valuable in identifying ways to engage with next-generation programme concerns and innovations affecting YCSD. These include child injuries and children with disabilities as well as the effects on chil-
dren of climate change, conflict, globalization, urbanization and the proliferation of new technologies. Within the United Nations system, partnerships such as the H4 plus and REACH will continue to provide a platform for coordinated inter-agency efforts in health, nutrition and other areas. Adjusting strategies to meet the challenges of new contexts and to capitalize on lessons learned is one important way UNICEF will embrace new and more effective means of reaching every child.